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# **CITY OF CHICAGO WORKERS' COMPENSATION PROGRAM**

**GRANT THORNTON LLP  
FINAL REPORT  
MAY 10, 2019**



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## I. INTRODUCTION AND ASSIGNMENT OBJECTIVES

Grant Thornton LLP (“Grant Thornton”, “us”, “we”, “our”, or “team”) was retained by the City of Chicago (“City”) Corporation Counsel (“Counsel”) to assist Counsel by conducting a review and audit<sup>1</sup> of the Workers’ Compensation Program (“Program”) for the City covering calendar years 2017 and 2018.

Grant Thornton’s procedures were performed at the direction of Counsel. Counsel engaged us to assist the City with a review of the Program to identify potential patterns or instances of fraud, waste, and abuse (“FWA”) within the Program. Our assignment and procedures included:

- 1) The analysis of workers’ compensation benefits administered in 2017 and 2018 to assist the City in determining whether the Program:
  - a. provided workers’ compensation benefits in compliance with governing statutes, rules, and policies;
  - b. workers’ compensation costs are in line with comparable peer jurisdictions; and
  - c. provided workers’ compensation benefits indicative of FWA by employee claimants, medical providers, and law firms.
- 2) An assessment of the Program’s operations and processes, including any fraud prevention and detection processes and protocols.

The procedures we executed fall within four broad workstreams: fraud risk assessment, analytics (data analytics), testing (claims testing), and research (peer jurisdictional analysis).

The scope of our assignment determined by Counsel as set forth above, did not include investigative procedures designed to determine the root causes or a quantum of potential FWA. We did not conduct interrogative interviews seeking admission of guilt of perpetrating potential FWA against the Program. Grant Thornton also did not conduct electronic discovery (e.g., computer forensic imaging of Program employee work computers, obtaining forensically sound email populations of Program personnel and conducting a targeted search for information) or attempt to quantify the potential financial impact to the City’s financial statements or the Program of any of our adverse findings and observations as a result of the procedures we performed.

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<sup>1</sup> The use of the word “review” or “audit” in the scope of services of this assignment was not undertaken or performed as any form of assurance or attestation as defined by the American Institute of Certified Public Accountants (“AICPA”). Grant Thornton as a firm is neither providing an opinion on any financial statements or other information nor providing an attestation or other form of assurance with respect to our work. Further, Grant Thornton did not apply procedures to determine the Program’s financial reporting was in compliance with any specified requirements from the AICPA, generally accepted accounting principles (“GAAP”), or other pronouncements, regulations, or guidelines on accounting. The parameters of this assignment were determined at the direction of Counsel through a scoping process that identified objectives and the means to measure whether the objectives were met.

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## II. LIMITATIONS AND DISCLAIMERS

### a. Standards of Performance

Our scope of work is as set out in our engagement letter or otherwise agreed to, which is quoted in this report. Our analysis of the affairs of the Program does not constitute an audit, review, or compilation in accordance with auditing and attestation standards and, consequently, we do not express an opinion on the figures included in the report. Because our services are limited in nature and scope, they cannot be relied upon to discover all documents and other information or provide all analyses that may be of importance in this matter. Accordingly, we make no representations regarding the sufficiency of our procedures for your purposes. Our services were provided in accordance with the Statement on Standards for Consulting Services promulgated by the American Institute of Certified Public Accountants and, accordingly, neither constitute a rendering by Grant Thornton LLP or its partners or staff of any legal advice, nor do they include the compilation, review, or audit of financial statements, as defined by the AICPA. Grant Thornton's project planning was conducted at the direction of Counsel and execution of our work was performed with objectivity and integrity; however, our work was not intended to be performed in accordance with the AICPA's generally accepted audit standards ("GAAS")<sup>2</sup>. Unless specifically stated herein, we did not validate the accuracy or completeness of any data or information provided to perform our procedures. The scope of the assignment has been limited to analyses of documents and data, along with information provided in interviews that have all been provided by the City, City employees, or City contractors. As such, we cannot be relied upon to discover all documents and other information or provide all analyses that may be of importance to the operations and administration of the Program. Although Counsel asked us to identify indications of FWA of which we become aware, our responsibility for the assignment was not specifically to conduct an investigation into possible fraudulent activity perpetrated within or against the Program. We neither conclude on the existence of possible fraudulent activity nor do we attempt to define what the whole population of possible FWA occurrences could be.

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<sup>2</sup> GAAS is intended to serve as the authoritative guidance in an assurance engagement, in which "the objective of the ordinary audit of financial statements by the independent auditor is the expression of an opinion on the fairness with which they present, in all material respects, financial position, results of operations, and its cash flows in conformity with generally accepted accounting principles" (*AU 110 "Responsibilities and Functions of the Independent Auditor"*). This assignment is a consulting engagement as defined by our professional guidance. *The Statement on Standards for Consulting Services (CS Section 100)* applies, in particular *paragraph .06* which requires as "Standards for Consulting Services" the following: a) professional competence, b) due professional care, c) appropriate and adequate planning and supervision, and d) an obligation to seek out sufficient relevant data. Further, *CS 100, paragraph .02* defines the following: "The nature and scope of work is determined solely by the agreement between the practitioner and client." Further, *paragraph .05 sub b)* defines "advisory services, in which the practitioner's function is to develop findings, conclusions, and recommendations for client consideration and decision making". This was the guidance Grant Thornton relied upon in conducting the work regardless of the naming convention (i.e., "audit") used by the City in its request for proposal to conduct this engagement.



## **b. Limitations on Distribution**

This report contains sensitive and confidential information proprietary to the City. It is restricted for the use and distribution to the parties of our engagement letter, and should not be disclosed to unauthorized third parties. We have not and shall not be deemed to assume any duties or obligations to any third party. This report is privileged and confidential and intended for the sole use by Counsel for whom it was prepared and to whom it was addressed. It is limited to the specific scope and activities agreed to with Counsel. This report may not be copied, reproduced, disseminated, distributed, or otherwise made available to any third party, in whole or in part, without the express prior written consent of Grant Thornton LLP. Grant Thornton LLPs consent may be withheld for any reason. In preparing this report, Grant Thornton LLP used professional care and diligence and relied upon the information provided by the City and other sources for our analysis. No representation or warranty, express or implied, is made by Grant Thornton LLP as to the accuracy or completeness of the information relied upon and included in this report. If the City wishes to disclose or disseminate in any manner any portion of any deliverable, other than the public report that Grant Thornton will assist the City with preparing, to a third party, the City agrees to first (i) provide Grant Thornton LLP with a draft of the proposed disclosure, (ii) obtain Grant Thornton's advance written approval, and (iii) if requested, obtain from the third party and provide to Grant Thornton a non-disclosure agreement and/or release in a form satisfactory to Grant Thornton in its sole discretion. Grant Thornton LLP acknowledges and accepts that all information and records supplied to and created for the City are public records and subject to public disclosure, and in the normal course of its duties, the City may also use this information to prepare related documents that are released to the public. Notwithstanding the City's permission to use the information provided, any work product, deliverables, or documents delivered by Grant Thornton LLP shall be released only as redacted in accordance with law or with the prior written permission of Grant Thornton LLP. This report is not to be used for any other purpose, and we specifically disclaim any responsibility for losses or damages incurred through the use of this report for a purpose other than as described in our engagement letter.

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### III. EXECUTIVE SUMMARY

Based upon the procedures we performed and information made available to us as of the date of this report, the City's Workers' Program is in need of substantial improvement to operate more effectively as well as prevent and detect potential fraud, waste, and abuse ("FWA"). While we were not tasked with nor did we investigate potential instances of fraud, we did identify significant control deficiencies and weaknesses that would create an environment where FWA could be present.

Of the workers' compensation claims we tested, the majority were not in compliance with governing statutes, rules, or the Program's internal claim administration guidelines in varying degrees of severity. Contributing factors to these results included the Program not maintaining its operations based on commonly accepted workers' compensation industry best practices and an inadequately trained workforce. In addition, the Program likely did not consistently provide workers' compensation benefits in compliance with governing statutes, rules, or the Program's internal claim administration guidelines.

We attempted to obtain comparable claims data from 19 peer agencies and jurisdictions, including major metropolitan areas. The data we did receive from seven different sources is not specifically comparable to that of the City's Program for a variety of reasons detailed in the report. Any attempt to determine whether the City's workers' compensation costs are or are not in line with those comparable peer jurisdictions would require additional data that was not available to us to analyze. Some jurisdictions provided limited data and others were non-responsive.

In all, we interviewed or interfaced with nearly 50 individuals including 28 current or former employees of the Program, City executives and other departmental personnel, third parties providing claims administration services to the Program, and outside counsel to which the Program referred some workers' compensation claims. Without exception, those individuals we interviewed or interfaced with were cooperative.

The City should evaluate whether it should invest the resources to substantially improve the Program to enhance its control environment and its operations, or whether the City should invest the resources to outsource the Program's administration of workers' compensation benefits to a third party that specializes in the administration of workers' compensation benefits. Either course of action will likely result in cost savings to the City over time, but in conjunction with its evaluation of the best course of action to take the City should estimate the likely cost savings and whether that cost savings can be achieved within a timeframe acceptable to the City.

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## IV. BACKGROUND, DEFINITIONS, AND KEY SOURCES OF INFORMATION

### a. Background

As of April 1, 2019<sup>3</sup>, the Program will be administered by the Department of Finance (“DOF”), which is a function of the Executive Branch of the City government. Prior to April 1, 2019, the Program was administered by the Committee on Finance (“COF”) of the City Council, which is a part of the Legislative Branch of the City government.

The Program administers workers’ compensation benefits for four City employee groups – Civilian, Police and Fire, Aviation, and Federally Funded Civilian<sup>4</sup> – as follows:

- Aviation and Federally Funded Civilian personnel have all aspects of workers’ compensation claims (hereinafter referred to as “workers’ compensation claims” or “claims”) administered by a third-party administrator, Cannon Cochran Management Services, Inc. (“CCMSI”) (<https://www.ccmsi.com/>);
- Police and Fire<sup>5</sup> personnel have managed medical and medical claims administered through the Program. Indemnity and life reserves claims<sup>6</sup> are administered by the individual departments, the Police Department and the Fire Department, respectively; and,
- Civilian personnel have all aspects of workers’ compensation administered by the Program.

The Program employees have functioned under the following organizational structure: a Director of Workers’ Compensation, Assistant Director, Civilian Workers’ Compensation Manager, Claims Counsel, claims adjusters (segregated by claim type), Investigators, and administrative support. Also, Coventry Healthcare Workers’ Compensation, Inc. (“Coventry”) reviewed and adjusted medical bills for Civilian and Police and Fire workers’ compensation claims.

The City’s Department of Law (“DOL”) Torts Division is responsible for handling workers’ compensation claims that involve arbitration or litigation proceedings as part of the claim adjudication process. Certain claims are referred to one of several external law firms to assist with the claim adjudication process including subrogation (e.g., Hennessy & Roach, P.C., Coghlan Law LLC, and others).

The Program has operated for many years with little to no monitoring and oversight by any other City departments who may have otherwise had the jurisdiction to do so. Some of these departments have requested access to the Program’s records for review, including the City of Chicago Office of Inspector General (“OIG”), but it is our understanding the Program or the COF may not have always produced a complete set of responsive information, may have denied the request, or not fulfilled the request. For example, one such request was fulfilled with the caveat that information would be limited to information permissible under the Illinois Freedom of Information Act and the Health Insurance Portability and Accountability Act of 1996.

<sup>3</sup> Unless otherwise noted, all Grant Thornton findings and observations within this report are based on the Program’s operations from January 1, 2017 through March 31, 2019.

<sup>4</sup> Federally Funded Civilian describes those employees whose salaries are paid through federal funding sources.

<sup>5</sup> Police and Fire as a term used in this report is inclusive of sworn police officers and firefighters as well as the civilian employees who work within the Police and Fire Departments, respectively.

<sup>6</sup> Claim types are classified as follows: a) indemnity, b) managed medical, c) life reserves, and, d) medical only.





## **b. Definitions**

Average Weekly Wage ("AWW") – calculated based on the claimant's weekly wage in the 52 weeks prior to the date of the injury, per the Illinois Worker's Compensation Act ("Act"). The Act addresses several factors impacting the calculation such as; disqualifying bonuses and overtime for purposes of the calculation, employees who have been employed by the employer for less than 52 weeks, employees who have lost 5 or more working days during the 52 week period, and employment by another employer which the liable employer had knowledge of prior to the injury. Per the Act, indemnity benefits for TTD (*see definition below*) are calculated as 66 2/3 percent of AWW. Permanent Partial Disability entitles the claimant to 60 percent of AWW.

CCMSI – CCMSI manages all claims submitted by employees whose positions are Federally Funded Civilian and those who are employed by the Department of Aviation. CCMSI uses a combination of Program-issued Client Service Instructions and its internal Corporate Claims Best Practices to manage claims.

Coventry – Using its own medical bill review system called Coventry Connect, Coventry adjusts bills according to Illinois Worker's Compensation Commission Medical Fee Schedule ("fee schedule"). Coventry also provides Nurse Case Management, Utilization Review ("UR"), and Independent Medical Exam ("IME") services to the Program.

Indemnity claims – Claims for medical expenses and Total Temporary Disability ("TTD" or "Total Disability" or "TD") benefits that are due to the claimant (employee) while they miss work because of the subject injury (ies).

Insurance Services Office ("ISO") ClaimsSearch – ISO ClaimSearch is a third-party service offering that provides statistical and actuarial information along with various advisory services. ISO is widely used in the insurance industry to obtain data about past losses, predict future losses, and satisfy other regulatory requirements such U.S. Department of Treasury - Office of Foreign Assets Control searches.

iVOS – The claims management system of record for the City of Chicago's Workers' Compensation Program.

Life Reserves claims – Claims for lifetime medical expenses due to catastrophic injury. The claimant will most likely be unable to seek any other employment because of the extent of the subject injury (ies).

Managed Medical claims – Claims for complex medical care that require a higher level of care oversight, coordination, and resources.

Maximum Medical Improvement ("MMI") – MMI is a treatment plateau in each claimant's healing process. It can mean that the claimant has fully recovered from the injury or that the claimant's medical condition has stabilized to the point that no major medical or emotional change can be expected in the claimant's condition. The claimant has, or is, receiving Temporary Total Disability benefits related to the claim.

Medical Only claims – Claims for only medical expenses that are generally related to simple injuries requiring simple medical care and no time off work, meaning no TTD benefit liability.



Pending claims – Claims that have been received by the Program but whereby final categorization and disposition are still under review by the Program.

Record Only claims – Claims that are filed with the Program, but do not result in medical expense or TTD liabilities. It is in the best interest of employers to adequately manage Record Only claims in the event the claimant decides to seek medical treatment after the fact, or the injury contributes to complications in the future. Record Only claims should not have any associated benefit payments.

Subrogation – This is a term describing a legal right to pursue a third party that caused a loss (e.g., a workers' compensation claim expense) incurred by the City, which then makes its own claim against others who may have caused the loss, insured the loss, or contributed to the loss. This is done in order to recover the amount of the claim paid by the City for the loss it incurred.

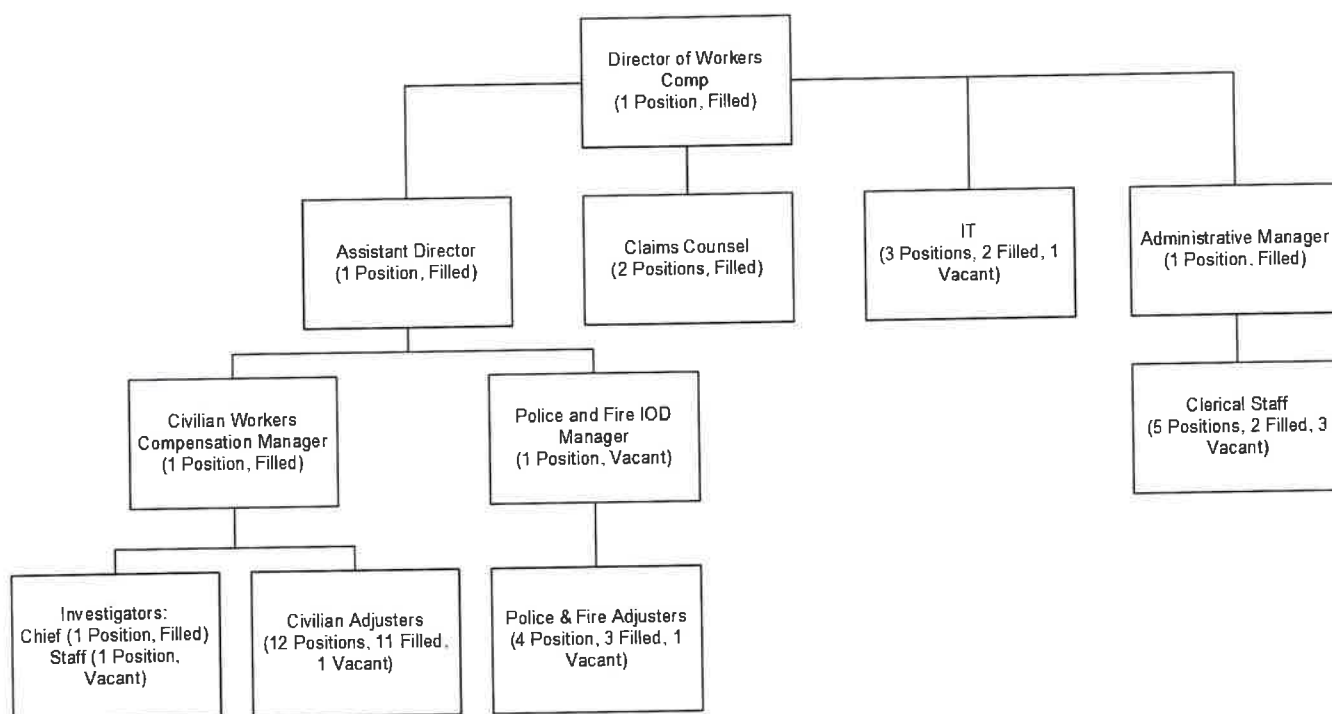
Temporary Total Disability ("TTD") and Temporary Disability ("TD") – Benefit put forth by the Act designed to temporarily compensate the injured worker during the duration of his or her disability.



### c. Key Sources of Information

To understand the organizational structure, processes, and history of the City's Program, Grant Thornton requested, gathered, and analyzed several sources of information. While this is not an exhaustive list of information obtained and reviewed, the items below represent key sources of information we relied upon during the course of the engagement:

1. An organization chart for the Program as of February 1, 2019, provided by the DOF:



2. Individuals interviewed by Grant Thornton (unless otherwise noted, all individuals listed are from the Program):
  - a. Director of Workers' Compensation
  - b. Assistant Director
  - c. former Assistant Director
  - d. two Claims Counsel
  - e. Administrative Manager
  - f. Civilian Workers' Compensation Manager
  - g. Chief Investigator
  - h. eleven Civilian Adjusters (overseeing indemnity, medical, managed medical, and life reserves claims)
  - i. three Police and Fire Adjusters



- j. two Clerical Staff
  - k. one Information Technology ("IT") employee (System Administrator)
  - l. three DOL Torts Division lawyers
  - m. Inspector General, OIG
  - n. Deputy Inspector General for Audit, OIG
  - o. Deputy Inspector General for Investigations, OIG
  - p. General Counsel for OIG
  - q. Deputy General Counsel for OIG
- 3. iVOS claims data for Civilian and Police and Fire for 2017 and 2018
  - 4. CCMSI claims data for Federally-Funded Civilian and Aviation for 2017 and 2018
  - 5. Coventry medical data for Civilian and Police and Fire for 2017 and 2018
  - 6. Program employees' payroll data for 2017 and 2018
  - 7. Current Program employees' resumes
  - 8. The DOL's historical list of workers' compensation claims requiring litigation support
  - 9. Hennessy & Roach, P.C. list of workers' compensation claims referred to the firm
  - 10. COF's list of claims referred externally for legal services
  - 11. The OIG's list of workers' compensation claim complaints received and those resultant claim complaints the OIG referred to the Program for its review
  - 12. A sample of an OIG investigative report regarding a workers' compensation claimant
  - 13. Copy of an *unsigned* agreement between the COF and Coventry from 2008
  - 14. Correspondence from the COF and Jenner & Block LLP regarding the OIG's requests for documentation from the Program
  - 15. Program employee list given to the OIG by the Department of Human Resources
  - 16. Background documents provided by the OIG:
  - 17. Collective bargaining agreements ("CBA") for the Police and Fire departments
  - 18. CCMSI policies and procedures for Federally Funded Civilian claims management and Aviation claims management
  - 19. Claims Management Guide utilized by the Program
  - 20. Peer jurisdiction workers' compensation data from select peer agencies and jurisdictions including the City's Program data from years 2014-2018 (see more details in **Section VIII**)

Grant Thornton requested documents that could not be or were not provided as of the date of this report including:

- 1. The COF's policy on contracting with third parties
- 2. Coventry's policy on medical bill review and payment processes
- 3. Risk Console user guide and sample reports
- 4. List of claims handled by Coghlan Law LLC and other applicable law firms for legal support and subrogation

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## V. FRAUD RISK ASSESSMENT

### a. Workstream Summary

Grant Thornton performed fraud risk assessment procedures over the Program to identify potential fraud risks and make actionable recommendations for improvement. Utilizing the five principles introduced in the Committee of Sponsoring Organizations of the Treadway Commission (“COSO”) Fraud Risk Management Guide (“COSO Guide”): Fraud Risk Governance, Fraud Risk Assessment, Fraud Control Activities, Fraud Investigation and Corrective Action, and Fraud Risk Management Monitoring Activities, Grant Thornton determined the Program’s overall fraud risk maturity aligns with *Level One (Ad Hoc)* of our fraud risk maturity model (see **Figure 1**). We evaluated and rated the Program’s fraud risk activities across each of these principles and provided detailed findings and recommendations in **Section V.c. and Section V.d.**, respectively of this report.

### b. Procedures Performed

In correlation with realignment of the Program from the COF to the DOF, the City determined it needed additional information related to the fraud risks that could expose it to financial, operational, and reputational harm.

**Framework Methodology.** Grant Thornton’s fraud risk assessment framework is based on principles introduced in the COSO Guide. The COSO Guide was published in September 2016 with co-sponsor, the Association of Certified Fraud Examiners (“ACFE”). The COSO Guide builds on the COSO 2013 Internal Control — Integrated Framework that has been accepted as the framework most non-federal government entities and public companies have adopted. Principle 8 of the COSO 2013 Internal Control – Integrated Framework is, “The organization considers the potential for fraud in assessing risks to the achievement of objectives.” The COSO Guide applies to all industries and government entities and offers a blueprint for satisfying Principle 8, thus helping organizations to establish an overall fraud risk-management program. Further, it covers key fraud risk management components with suggested activities that result in fraud deterrence.

As noted above, Grant Thornton’s fraud risk maturity model is based on the five principles of the COSO Guide. See **Table 1** below for the COSO Guide’s definition of the five key fraud risk principles essential to an effective fraud risk-management program. We assessed the City’s Program using these five COSO principles as a benchmark for best practices in effective fraud risk management.





COSO Principle	Description
<b>Fraud Risk Governance</b>	<i>The organization establishes and communicates a Fraud Risk Management Program that demonstrates the expectations of the board of directors and senior management and their commitment to high integrity Control and ethical values regarding managing fraud risk</i>
<b>Fraud Risk Assessment</b>	<i>The organization performs comprehensive fraud risk assessments to identify specific fraud schemes and risks, assess their likelihood and significance, evaluate existing fraud control activities, and implement actions to mitigate residual fraud risks.</i>
<b>Fraud Control Activities</b>	<i>The organization selects, develops, and deploys preventive and detective fraud control activities to mitigate the risk of fraud events occurring or not being detected in a timely manner.</i>
<b>Fraud Investigation and Corrective Action</b>	<i>The organization establishes a communication process to obtain information about potential fraud and deploys a coordinated approach to investigation and corrective action to address fraud appropriately and in a timely manner.</i>
<b>Fraud Monitoring Activities</b>	<i>The organization selects, develops, and performs ongoing evaluations to ascertain whether each of the five principles of fraud risk management is present and functioning and communicates Fraud Risk Management Program deficiencies in a timely manner to parties responsible for taking corrective action, including senior management and the board of directors.</i>

**Table 1: COSO Fraud Risk Management Guide Categories**

**Current-State Fraud Risk Maturity Assessment Approach.** Grant Thornton began by collecting available documentation to understand the current state during the period in scope (2017 and 2018). Following our review of Program documentation made available to us, we developed a detailed fraud risk map to identify potential fraud schemes as well as the actors and channels associated with each of those schemes. The fraud risk map provided a broad view of program vulnerabilities and identified areas to be assessed further during interviews.

With an understanding of potential vulnerabilities, we conducted one-on-one or small group interviews with management and staff across the entire Program, including relevant external stakeholders such as the OIG and the DOL Torts Division. The information gathering and interviews provided a significant level of detail that enabled us to identify and classify various fraud risks and make actionable recommendations for improvement.

The fraud risk assessment findings relate to both internal and external fraud threats across the entirety of the Program, including claims related to the above-noted employee groups (see **Section IV.a.**).

Grant Thornton evaluated the maturity of the Program against COSO Guide principles on a continuum from Ad Hoc (1) to Leadership (5). The maturity model continuum is presented below in **Figure 1**. We



assessed the Program's maturity solely against this framework. For each of the five principles, we identified gaps between the Program and established benchmarks. These gaps are presented as findings with detailed recommendations in **Section V.c. and Section V.d.** of this report.



The contents of this document were prepared solely for the use of the City of Chicago Corporation Counsel in the normal course of discharging their duties. It is not to be used, relied upon or referred to by any other party for any purpose.

# GRANT THORNTON'S FRAUD RISK MATURITY MODEL



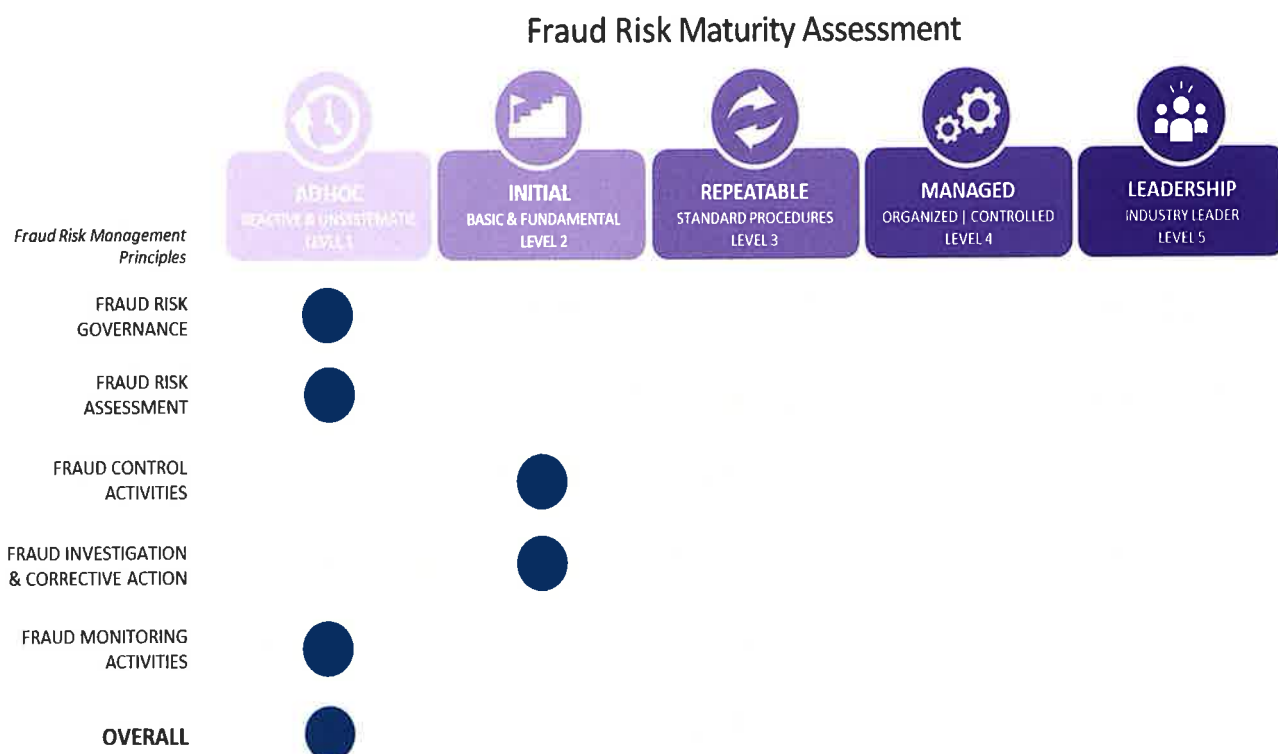
Figure 1: Grant Thornton's Fraud Risk Maturity Model



## c. Findings

### Maturity Assessment Results

Grant Thornton determined the Program's overall fraud risk maturity aligns with *Level One (Ad Hoc)* of our maturity model. This overall maturity level represents the aggregate score across all five COSO principles outlined in **Figure 2**. We evaluated and rated the Program's fraud risk activities across each of these principles. Detailed findings and recommendations are below-noted.



**Figure 2: Fraud Risk Assessment Results**

### COSO Principle 1: Fraud Risk Governance

The COSO Guide calls for organizations to establish and communicate fraud risk management policies that demonstrate the expectations of senior management and their commitment to integrity and ethical values regarding managing fraud risk. Based on Grant Thornton's evaluation, we determined the Program was operating at *Level One (Ad Hoc)* for this principle.

Grant Thornton noted the Program had no formalized governance or oversight structure, which contributed to an overall lack of activities and controls to prevent FWA. The following were key findings related to this COSO principle:



- The Program did not have a comprehensive enterprise fraud risk policy, including defined roles and responsibilities.
- The Program did not offer antifraud training.
- The Program did not conduct fraud awareness initiatives.

Each of these findings are below detailed.

**The Program did not have a comprehensive enterprise fraud risk policy, including defined roles and responsibilities.** The COSO Guide states that a fundamental principle of an effective fraud risk management policy is for all personnel to be cognizant that the organization does not accept fraudulent behavior of any kind. The Program had no documented policies or guidelines related to fraud and any antifraud activities we identified were inconsistent in their approach and application.

The COSO Guide states an organization should identify the roles and responsibilities of all personnel as they relate to fraud risk governance. The Program did not have any specific roles or responsibilities that related to fraud risk governance or management of fraud risks. Lack of clear roles and responsibilities introduces ambiguity regarding who is responsible for identifying and managing fraud risks as well as handling allegations of suspected FWA. This ambiguity could allow FWA to go unnoticed and/or unreported and creates significant risk for the Program.

**The Program did not offer antifraud training.** The COSO Guide calls for organizations to implement an enterprise-wide fraud-focused training course that is required for all employees on a recurring basis. Further, the COSO Guide states this type of enterprise-wide training provides a consistent basis for fraud awareness throughout the organization, which is a fundamental pillar of any fraud risk management effort. Grant Thornton noted the Program lacked any antifraud training material. Any job-specific training performed was conducted by more senior adjusters on an ad-hoc basis, and therefore, was not consistent in who received the training or at what level of detail.

**The Program did not conduct fraud awareness initiatives.** The COSO Guide states an organization should communicate the importance of fraud risk management at all levels of the organization, with a continued focus on fraud deterrence, prevention, and detection. Grant Thornton noted the Program documented a list of potential red flags within the "Claims Management Guide" to help claims adjudication staff identify potential issues (including fraud and other common problems) during the adjudication process. However, these red flags were simply provided as additional information and beyond this list of common red flags, Grant Thornton was unable to identify any efforts by the City or Program management to raise awareness about the risk of fraud as it relates to the Program. A lack of awareness about specific Program risks and red flags raises the likelihood that instances of FWA could go unnoticed.

## **COSO Principle 2: Fraud Risk Assessment**

The COSO Guide calls for organizations to perform comprehensive fraud risk assessments to identify specific fraud schemes and risks, assess the likelihood and significance of those risks, evaluate existing fraud control activities, and implement actions to mitigate residual fraud risks. Based on Grant Thornton's evaluation, we determined the Program was operating at *Level One (Ad Hoc)* for this principle.



The following key finding was related to this COSO principle:

- The Program had not performed a fraud risk assessment to identify and respond to fraud risks.

This finding is below detailed.

**The Program had not performed a fraud risk assessment to identify and respond to fraud risks.**

The COSO Guide states the fraud risk assessment process should be comprehensive and identify specific fraud schemes and risks across the organization. Once an organization has developed a standardized fraud risk assessment process, the organization should establish a fraud risk assessment team that includes the appropriate levels of management. Finally, the COSO Guide states the fraud risk assessment process should be repeated periodically and organizations should consider changes affecting the organization – such as changes in operations, personnel, and leadership – that can affect fraud risks and may trigger the need for a reassessment. Grant Thornton noted the Program had no standardized fraud risk assessment methodology and had never performed a fraud risk assessment. This presents significant risk to the Program, as the completion of a fraud risk assessment is needed to understand the sources of fraud risk, assess the likelihood and impact of fraud events, and determine appropriate risk responses based on the Program's risk tolerance and prioritization.

**COSO Principle 3: Fraud Control Activities**

The COSO Guide calls for organizations to select, develop, and deploy preventive and detective fraud control activities at various levels of the organization to mitigate the risk of fraud events. Based on Grant Thornton's evaluation, we determined the Program was operating at *Level Two (Initial)* for this principle. Grant Thornton assessed the Program at Level Two because it did have some internal controls in place, for example the Program employed segregation of duties controls for the claim adjudication, investigation, and review/approval roles. Additionally, the Program had a documented best practices guide, which included red flags to document indicators to help adjudicators identify potential fraud, waste, and abuse.

The following key findings are related to this COSO principle:

- The Program did not have any documented policies or procedures other than the Claims Management Guide.
- The Program had limited fraud control activities.
- The Program did not employ proactive data analytics.
- The Program was not able to produce – and so it can be presumed the Program does not maintain – fully executed contracts with third parties.

These findings are below detailed.

**The Program did not have any documented policies or procedures.** The COSO Guide states organizations should thoroughly document and implement their control activities through formal policies and procedures. Grant Thornton noted the Program did not have any written policies or procedures except for the Claims Management Guide that included potential red flags and was last updated in 2015. Without thoroughly documented policies and procedures, control activities will not be institutionalized and may not be implemented consistently across the Program.





**The Program had limited fraud control activities.** Grant Thornton noted the Program developed and implemented some internal controls and processes to identify and investigate potential FWA in workers' compensation claims and related medical bills. However, we noted the Program did not have adequately documented policies and procedures to ensure consistent application of fraud control activities across all business processes and did not take actions to determine their effectiveness in preventing or detecting potential cases of FWA. Further, the Program did not have a process to assess fraud risks; therefore, it did not take a coordinated approach to identify control gaps and develop preventative and detective controls in response to program risks and gaps.

**The Program did not employ proactive data analytics.** The COSO Guide states organizations should implement a system of data analytic processes and procedures to identify anomalous transactions or events for further investigation. Grant Thornton noted the Program does not use either software it is currently licensed to use or software readily available in the market to perform data analytics to identify potential FWA. Program management informed Grant Thornton a dashboard is used to track medical claims processing metrics on a monthly basis. However, the Program's use of analytics was limited to tracking workflow status and did not employ analytic methods to prevent or detect suspicious transactions for further investigation. The Program informed us it utilizes a tool, Risk Console, to assist with some data analytics. We requested samples of reports and the tool's user guide, but as of the date of this report, the Program has not provided these requested items.

**The Program was not able to produce – and so it can be presumed the Program does not maintain – contracts with third-party service providers.** The COSO Guide calls for organizations to analyze all fraud risks, including external risks, and their impact on the organization's objectives. This analysis is not entirely possible without fully understanding the rights and obligations related to relationships with service providers. The Program was only able to produce an unsigned copy of its agreement with Coventry. As such, Grant Thornton was unable to examine whether the contracts or the process by which they are awarded would have presented FWA risks to the Program.

#### **COSO Principle 4: Fraud Investigation and Corrective Action**

The COSO Guide calls for organizations to establish a communication process to obtain information about potential fraud and deploy a coordinated approach to investigation and corrective action to address suspected fraud appropriately and in a timely manner. Based on Grant Thornton's evaluation, we determined the Program was operating at *Level Two (Initial)* for this principle.

The following key findings are related to this COSO principle:

- The Program did not maintain an anonymous fraud tip hotline to facilitate internal or external referrals for potential fraud.<sup>7</sup>
- The Program's investigations function did not have documented policies or procedures to ensure consistent, reliable investigations.

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<sup>7</sup> Grant Thornton noted the Program received anonymous fraud tips related to the Program or claims through the OIG.



These findings are below detailed.

**The Program did not maintain an anonymous fraud tip hotline to facilitate internal or external referrals for potential fraud.** The Program indicated that any cases of suspected fraud were to be addressed by Program leadership, which could potentially discourage reporting of suspected cases of internal fraud schemes perpetrated by Program personnel. The ACFE noted in its *2018 Report to the Nations* that organizations with hotlines identified 46 percent of fraud cases due to tips, versus only 30 percent of fraud cases at organizations without hotlines. Additionally, according to the ACFE, tips are the most common initial detection method, accounting for 40 percent of cases. Internal audit and management review, by comparison, only accounted for 15 percent and 13 percent, respectively.

**The Program's investigations function did not have documented policies or procedures to ensure consistent, reliable investigations.** Grant Thornton noted the Program operated an investigations function that was staffed by former Chicago Police Department officers with criminal investigation experience. The Program's investigations personnel collected written and verbal witness statements and conducted surveillance on claimants suspected of exaggerating or falsifying injury claims. These processes were repeatable and offered a proactive way to address potential FWA before a claim was adjudicated and payments began. However, Grant Thornton determined based on interviews, the Program did not have formal, standardized investigation policies or procedures. Program staff also indicated investigation documentation was often inconsistent or incomplete and hindered the claims adjudication teams' ability to make well-informed adjudication determinations. It is also noteworthy the Program did not have a conflict of interest policy prohibiting or instituting controls over the Program's investigations personnel from investigating Chicago Police Department personnel claims.

### **COSO Principle 5: Fraud Monitoring Activities**

The COSO Guide calls for organizations to select, develop, and perform ongoing evaluations to ascertain whether each of the five principles of fraud risk management is present and functioning and communicates fraud risk management program deficiencies in a timely manner to parties responsible for taking corrective action, including senior management. Based on Grant Thornton's evaluation, we determined the Program was operating at *Level One (Ad Hoc)* for this principle.

The following key finding is related to this COSO principle:

- The Program did not perform monitoring evaluations to determine whether each of the five principles of fraud risk management were present and functioning.

This finding is below detailed.

**The Program did not perform monitoring evaluations to determine whether each of the five principles of fraud risk management were present and functioning.** Grant Thornton observed the Program was not performing activities related to principle one (Fraud Risk Governance) or principle two (Fraud Risk Assessment). Therefore, it had not implemented activities to monitor and evaluate the effectiveness of activities related to these principles. Our team noted the Program did perform basic antifraud control activities as well as investigations to support adjudication determinations. However,



the Program did not have standardized monitoring activities to determine the effectiveness of its control activities or investigations process.

#### **d. Recommendations**

The major findings and activities identified during our fraud risk assessment workstream, described above, have contributed to Grant Thornton assessing the Program's overall fraud risk maturity level at *Level One (Ad Hoc)*. Grant Thornton assessed the Program at Level One because its fraud risk management processes were largely missing or undocumented. Further, the activities we identified were being performed in an ad-hoc, reactive manner by Program personnel. Because of this, successful efforts to consistently prevent or detect FWA were highly likely to depend on individual efforts and were not considered to be repeatable because processes were not sufficiently defined and documented to allow them to be replicated.

The fraud risk maturity model above set forth is an effective tool to help the Program understand its current state as well as determine an appropriate goal state. It is important to note that the fraud risk maturity model is intended as a guide, and the Program should weigh the relative costs and benefits of achieving higher levels of maturity across the COSO Guide's five principles. Not all organizations need to achieve the *Leadership* level for all principles to see significant benefits from their antifraud efforts. The sections below provide targeted recommendations to help the Program address our specific findings and achieve a higher level of antifraud program maturity to help ensure taxpayer resources are safeguarded against FWA.

#### **COSO Principle 1: Fraud Risk Governance**

Overall, fraud risk governance should be the first focus in developing a fraud risk management program. For the Program to progress in maturity, Grant Thornton recommends the following actions:

##### **1. Fraud Risk Management Policy.**

- a. Establish a comprehensive fraud risk management policy that includes broad policies and principles that guide personnel conduct.
- b. Document the defined roles and responsibilities of all Program personnel as they relate to fraud risk governance within the fraud risk policy.
- c. Define and distinguish internal and external fraud definitions within training materials and within the future antifraud program.

2. **Antifraud Training.** Grant Thornton recommends the Program develop a comprehensive in-person antifraud training and require all Program employees attend the training on an annual basis. The Program should also develop tailored training content for specific roles and levels, such as claims adjudicators and investigators, which require specific knowledge of antifraud policies, processes, and control activities. While Program-wide training provides a solid foundation, more advanced and detailed antifraud training would help ensure Program management and staff understand the relevant fraud risks, red flags, and know how to report suspected FWA.



We recommend as a starting point to develop Program-wide training that follows basic best practices including:

- a. Define external fraud
- b. Provide examples of past schemes, other unethical behavior, and red flags
- c. Instruct individuals on how to report potential FWA
- d. Inform of disciplinary action for policy violation
- e. Develop a training plan which documents:
  - i. Employees and third parties to receive training
  - ii. Which training programs apply to each job function
  - iii. A schedule for training by level and job function

Lastly, the Program should keep records of training completion enabling them to monitor employees who are not compliant.

3. **Fraud Awareness Initiatives.** Promoting fraud awareness throughout the Program from the top down is vital to creating a strong antifraud culture. It is important to conduct fraud awareness initiatives to demonstrate Program leadership's commitment to proactively addressing fraud risks. The Program should promote awareness through training, codes of conduct, fraud discussions at recurring team meetings, and frequent communications (e.g., town hall/department meetings, fraud email newsletters). Additionally, the Program should coordinate with the OIG to publicize information about antifraud efforts and successfully resolved FWA cases to raise awareness about the consequences of committing fraud, which acts as a deterrent to potential perpetrators of fraud.

## **COSO Principle 2: Fraud Risk Assessment**

For the Program to progress in maturity, Grant Thornton recommends the following actions:

1. **Develop and Implement a Recurring Fraud Risk Assessment.** The Program should develop and implement a fraud risk assessment methodology based on the following COSO leading practices:
  - a. Involve appropriate levels of management
  - b. Involve staff from across all roles and levels of the Program
  - c. Analyze both internal and external fraud risks and their impact on the achievement of objectives
  - d. Consider various types of fraud beyond the typical financial fraud schemes (see the fraud risk map in **Appendix A** for a list of common workers compensation fraud schemes)
  - e. Continue to mature and incrementally improve the process with each iteration
  - f. Estimate the likelihood and significance of risks identified
  - g. Establish a fraud risk tolerance which considers the balance between risk and reward
  - h. Develop risk responses based on the Program's risk tolerance
  - i. Incorporate controls into the risk assessment and identify and prioritize remediation activities
  - j. Establish a schedule to reexamine fraud risks periodically or as changes occur that could affect the Program





The fraud risk assessment forms the foundation for how an organization identifies and responds to its fraud risks. Fraud control activities developed based on the risk assessment should consider both the potential fraud schemes and the individuals within and outside the Program who could be the perpetrators of each scheme. The fraud risk map included in **Appendix A** provides a starting point for the Program to begin its risk assessment and develop control activities to address known vulnerabilities. As fraud risk management activities, including the fraud risk assessment, mature across the Program, City and Program personnel should revisit the fraud risk map and add new fraud schemes identified through experience, research of similar workers' compensation programs, and cross-departmental fraud risk brainstorming sessions.

### **COSO Principle 3: Fraud Control Activities**

Grant Thornton noted the Program developed and implemented limited antifraud controls and processes to identify potential FWA in workers' compensation claims and related medical bills. As above noted, the *ACFE 2018 Report to the Nations* found that internal control weaknesses were responsible for nearly half of fraud cases. Furthermore, the ACFE noted data analytics accounted for losses that were 52 percent lower than organizations that did not employ analytics because analytics led to quicker detection. For the Program to progress in maturity, Grant Thornton recommends the following actions:

1. **Periodically Update Current Claims Management Guide.** The Program should continue updating the Claims Management Guide with best practices, red flags, and other useful resources (e.g., checklists, ACFE reference material). Fraud schemes are dynamic in nature and organizations must adapt to new schemes and perpetrators to stay ahead.
2. **Incorporate the Use of Proactive Data Analytics.** The Program should implement a system of data analytic processes and procedures to identify anomalous transactions or events for further investigation. This includes analyzing medical claims data received from Coventry to identify suspicious billing patterns across service types and providers. The Program should develop a process for investigating and taking action for anomalous transactions including the application of treatments (e.g., additional reviews for suspicious providers or types of medical services) to reduce the likelihood of FWA. The Program should consider using data analytic software available in the market to detect and prevent potential FWA (see **Section VI.d.**).
3. **Develop Policies and Procedures with Documented Fraud Control Activities.** The Program should develop policies and procedure guides for key business processes to ensure consistent application of fraud control activities across all Program staff. The policies and procedures should formally document key preventative and detective control activities. While we acknowledge the City does have some of these control activities, examples of common fraud control activities include the following:



ACFE Common Fraud Control Activities	
1. Rewards for whistleblowers	10. Employee support programs
2. Job rotation/ mandatory vacation	11. Fraud tip hotline
3. Dedicated fraud department, function, or team	12. Independent audit committee
4. Formal fraud risk assessments	13. Internal audit department
5. Proactive data monitoring and analysis	14. External audit of internal controls
6. Surprise audits	15. Management certification of financial statements
7. Fraud training for management	16. Management review
8. Fraud training for staff	17. Code of conduct
9. Antifraud policy	18. External audit of financial statements

Additionally, the Program should establish a periodic assessment process, including reviews performed by the OIG, to determine whether staff are performing the controls as defined in the policies and procedures and determine their effectiveness at preventing and detecting FWA. The most effective assessment programs include both internal reviews performed by management as well as reviews performed by external oversight bodies, such as the OIG.

4. **Periodically Review Contracts with Third Parties.** The Program should continually monitor compliance with third party contracts. This will allow City and Program management to identify any risks of FWA that may be result from these relationships. The Program should also ensure that any future procurement be well documented and in compliance with any applicable City ordinance, and/or local, State, and federal law.

#### COSO Principle 4: Fraud Investigation and Corrective Action

1. **Develop and Implement an Anonymous Fraud Tip Hotline.** Hotlines are consistently the most effective method in fraud detection. Therefore, an effective fraud tip hotline platform should be well-established. Hotline best practices and recommendations include:
  - a. Access information (phone number and/or email address) should be provided to staff and third parties.
  - b. Hotline capabilities should include: 24/7 availability, multilingual capability, multiple channels of reporting (e.g., phone, email, mail, etc.), and anonymous reporting.
  - c. Development of the hotline should be accompanied by publication of clear whistleblower protections for any City employees that report internal fraud tips.

While we acknowledge the OIG does receive some tips of FWA related to claims the Program handles(ed), the Program should work with the OIG to establish a formal anonymous FWA tip hotline that is either specific to the City's workers' compensation benefit administration or is integrated into any existing anonymous FWA tip hotlines the OIG maintains and manages.

2. **Document Policies and Procedures for Investigations.** Grant Thornton noted the Program operated an investigations group that was staffed by former Chicago Police officers with experience



performing criminal investigations. However, investigations into potential workers' compensation benefits FWA requires special investigative skillsets, processes, and procedures that may not be part of the law enforcement training or experience of former police officers. Furthermore, the Program should consider the benefit of using investigative resources experienced in investigating potential workers' compensation benefits FWA that are not former Chicago Police officers to avoid potential conflicts of interest. Grant Thornton recommends the Program work with the OIG to develop clear roles and responsibilities and document formal policies and procedures related to adjudication interviews and investigations to clearly identify at which point a potential FWA case should be referred to the OIG's Investigations team and to avoid potential conflicts of interest. The policies and procedures for the adjudication investigations and witness interviews should include clear standards for completeness and quality to facilitate a stronger adjudication determination and documentation process.

### **COSO Principle 5: Fraud Monitoring Activities**

1. **Incorporate Analytics and Establish Appropriate Measurement Criteria.** The COSO Guide calls for organizations to establish measurement criteria to monitor and improve fraud prevention and detection, as well as provide the utilized criteria to the organization's leadership on an ongoing basis. The Program should explore opportunities to incorporate data from the adjudication process as well as from medical claims and other key areas to develop performance metrics to better monitor effectiveness. In line with the COSO Guide, establishing appropriate benchmarks and metrics to guide Program management's decision making process will elevate the Program's maturity level.
2. **Consider Factors for Setting the Scope and Frequency of Evaluations.** The COSO Guide states organizations should consider factors for setting the scope and frequency of evaluations. This includes the consideration of changes in the organization, its operating environment, and its control structure to determine the appropriate scope and frequency of its fraud risk management monitoring activities. As fraud risks are prioritized, the Program should continuously consider the scoping and frequency of antifraud monitoring activities. For instance, changes in the Illinois State workers' compensation laws would potentially require a limited scope risk assessment to determine the impact of the changes on the Program's fraud risks.
3. **Evaluate, Communicate, and Remediate Deficiencies.** The COSO Guide states organizations should assess the results of separate and ongoing monitoring evaluations, communicate deficiencies to those responsible for corrective action, and determine that appropriate remediation activities are implemented in a timely manner. As the Program is still in the early stages of developing and implementing monitoring activities, the process for evaluating, communicating, and remediating deficiencies identified as part of these monitoring activities should be considered. In an ideal state, the processes for evaluating, communicating, and remediating deficiencies identified should be formal and documented in a policy or procedure to ensure roles, responsibilities, and processes are clear and well-defined. Once developed, these processes should be implemented alongside monitoring activities put in place.

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## **VI. DATA ANALYTICS**

### **a. Workstream Summary**

Grant Thornton was tasked to perform analyses using data and knowledge collected from the Program to determine whether there are any indications of potential FWA. We performed multiple analyses to identify outliers within data extracted from the ICE and iVOS claim systems. We developed a set of business rules to guide these analyses based on knowledge gained from interviews with Program and City personnel and Grant Thornton's collective experience with FWA data analytics and workers' compensation industry experience.

Grant Thornton has provided analyses and visualizations of the claims data as examples of methods that should be undertaken as a standard matter. To this end, Grant Thornton recommends the City and Program perform such analyses regularly in order to identify outliers in their claims data, and further review specific claims that are identified as outliers. Grant Thornton has identified potential anomalies in the existing data, as well as more general recommendations around how the City can continually monitor potential instances of FWA in the Program.

### **b. Procedures Performed**

Grant Thornton performed data analytics around the Program. We executed several data procedures to build consistency and quality into the results produced, including a thorough review of the data currently maintained relating to the Program. We also identified several examples of analyses the City should consider using in the future to identify anomalies that can then be further reviewed in order to limit losses from FWA.

Grant Thornton applied analytic techniques to identify anomalies indicative of suspicious behavior across employee claimants, medical providers, and law firms. The data review period covers workers' compensation claim activity between January 1, 2017 and December 31, 2018. Our focus was on the following five elements:

#### **I. Collection and Understanding of Data**

##### **Development and Solicitation of Data Questionnaire and Request List**

In order to develop a better understanding of what information the City is capturing with regard to the Program and the necessary processes to do so, Grant Thornton prepared a list of questions for the Program's IT group. This questionnaire included topics intended to provide Grant Thornton a knowledge base of the data available to perform analyses relevant to the current FWA environment of the Program, including:

- Unique identifiers
- Personal employee data
- Claimant data
- Claim payment data





- Investigated claims data
- Legal representation data
- Medical data
- Claim metrics
- System(s) in which this data is stored

In addition to the data questionnaire, we submitted a supplemental data request list for data pertaining to payment of claims, detail of claims, agency/employee group of claimants, legal representation of claims, medical detail of claims, and employee records of claimants. The data request list contemplated variables of interest that are typically used to analyze for potential FWA that could affect the Program. These datasets allowed Grant Thornton to draw observations of the Program's environment and make recommendations to improve the environment going forward.

#### Review of Data Provided

As Grant Thornton received previews of the data contained in the claims data system, iVOS, each preview was reviewed, with specific consideration given to the time frame of data provided compared to the relevant review period, the variables included compared to the variables requested via the data request list, and the format of the data provided.

While the preview data was provided as samples to illustrate what was available, further review indicated the preview data format was not appropriate to support the intended analyses, as confirmed via conversations with the City. Grant Thornton was able to successfully clarify the data format needed from the City for analytics purposes.

## **II. Understand Existing Operations, Processes, and Systems**

#### Participation in Interviews

Grant Thornton conducted several interviews with employees involved with Program's claims administration to develop a better understanding of the systems used, procedures in place for processing claims, and other supplemental information regarding workers' compensation claims. Program management suggested a walkthrough of iVOS would be helpful for analytics purposes.

#### Participation in System Demonstration

Grant Thornton participated in a demonstration of the claims data system, iVOS, to aid in the understanding of what claims data exists in this system and how the information could potentially be extracted. Grant Thornton recognized during this demonstration the iVOS does not support data extraction in a format conducive to conducting data analytics. Grant Thornton and Program IT personnel subsequently conducted a WebEx virtual meeting to discuss how the claims data in iVOS could be produced in a format appropriate for data analysis.



### **III. Prepare for Complete Data Retrieval**

#### Establishment of Business Rules

While awaiting receipt of the data required for analysis, Grant Thornton developed logical business rules to serve as a basis for analysis once the data was received. These business rules were developed within four categories:

1. Claimant based rules
2. Medical provider based rules
3. Claim payment based rules
4. Law firm based rules

Grant Thornton created these business rules utilizing information collected in various interviews with Program personnel regarding claim processing and in collaboration with Grant Thornton team members with deep workers' compensation experience to configure the business rules based on specific insights and experience. The business rules are based on analytics best practices for identifying outliers, such as calculated comparisons to mean statistics and best practices within workers' compensation programs. These business rules allowed Grant Thornton to identify anomalies or areas in the Program where additional reviews should be considered for execution to limit FWA loss.

### **IV. Cleanse and Process Data**

Grant Thornton received data from the Program through three different sources:

- The Program's claim processing system, iVOS
- Coventry data related to its services to the Program
- CCMSI data related to its services to the Program

iVOS and Coventry data only relate to Civilian and Police and Fire claims, whereas CCMSI includes data specific to Aviation and Federally Funded Civilian claims. As we began analysis of the data, we discovered key identifiers to tie the disparate datasets together proved to be insufficient, and the data could not be fully merged for a comprehensive view. Thus, Grant Thornton analyzed data from the aforementioned three sources separately to ensure accuracy of analytic findings. The limitations of the data are detailed in the following section.

#### Data Constraints

In preparing the data, Grant Thornton discovered several data challenges and constraints that required additional data cleansing, and in some cases, impacted the types of analyses that could be completed. The challenges and constraints were as follows:

- Inconsistent data entry of individuals and entities such as providers, claimants, and law firms
- Inconsistent formatting of like fields, e.g., names of individuals
- Unique key identifiers that did not match across datasets
- Insufficient number of records in a population such as a particular claim type

To prepare the data Grant Thornton used to develop the analytic reports, we utilized R, an open source programming language and software environment for statistical computing and graphics, to develop code to cleanse the data and maintain consistent formatting. It was during this stage we determined



that not all unique identifiers were properly maintained across the various systems, thus preventing full integration of the data received, and limiting the associated analytics that could be performed. Grant Thornton was informed that the “ICN” number in Coventry and “Document Number” in iVOS are key identifiers that could tie data from the two systems. However, Grant Thornton found that the data provided did not properly match. After the data was cleansed, Grant Thornton joined several of the datasets together where unique identifiers existed.

In Grant Thornton’s efforts to join claim payment data with claim log data, not unexpectedly, we observed a number of claims incurred in previous years were still being paid out during 2017 and 2018 (**Figure 3**). With further analysis, we observed that approximately five (5) percent of claims were opened ten (10) years ago or longer and are still receiving payments.

Active Claims Receiving Payments by Year Opened

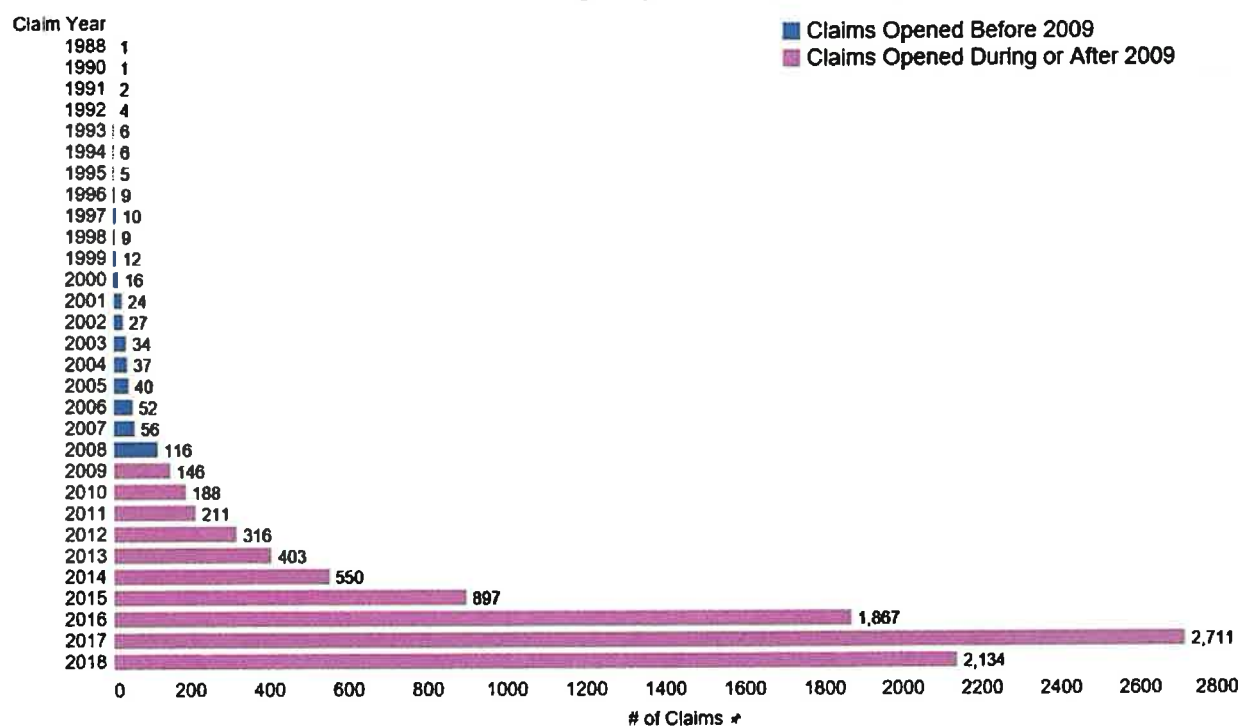


Figure 3: Active Claims Receiving Payments





## V. Develop and Perform Analytics

With the data cleansed and joined utilizing R, the next step was to derive several variables to represent elements of the business rules such as days between various dates and averages of several numeric fields. Grant Thornton then employed Tableau, a Business Intelligence (BI) platform, to support further analysis and anomaly detection. As we created data visualizations, Grant Thornton continuously re-evaluated the list of business rules previously developed, tailoring them to rules which could be applied to the data available.

The logical business rules guided each analysis, giving us a basis for the different fields and measures that should be compared across the Program data. The data visualizations we developed serve to identify anomalies within the data that merit further analysis and should be considered for further review by the City and the Program. Moreover, these should serve as a guide to the Program for future analysis, tracking, and monitoring of claims payments.

Grant Thornton performed analyses for each of the four subgroups: Civilian, Police and Fire, Aviation, and Federally Funded Civilian. However, due to the small volume of data for Aviation and Federally Funded Civilian claims compared to Civilian and Police and Fire, anomalous claims could not be as easily extracted through analyses on these datasets. Only analyses for which anomalous activity was detected are included in this report.

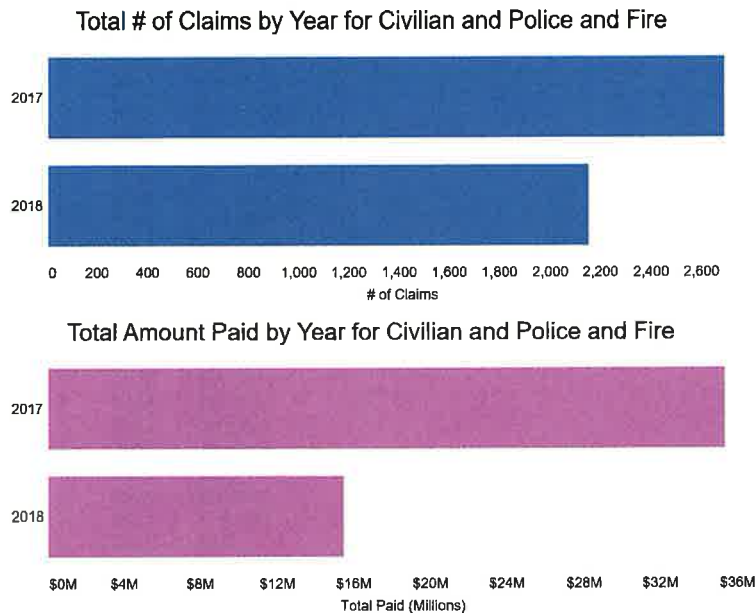
### c. Findings

As stated above, the Program should consider establishing consistent review processes and actively monitor claims through the claim lifecycle. Grant Thornton performed the following analyses to provide the City and the Program with example analyses that support the detection of potential signs of FWA impacting the Program. The Program can benefit from conducting similar analyses prospectively to aid in monitoring and reviewing claims throughout their lifespan. For purposes of this report, Grant Thornton has anonymized all personally identifiable information including names of individuals, claim numbers, and accident descriptions. In addition to that anonymization, any initials and claim numbers depicted within this report are not the actual employee initials or workers' compensation claim numbers.

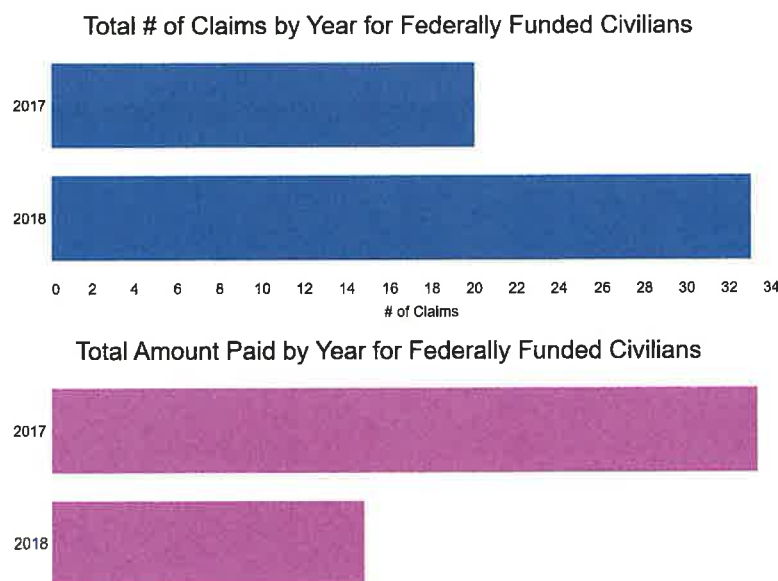
#### Year to Year Analysis

A comparison of claims from year to year allows for the identification of unexpected changes over time. Grant Thornton completed an analysis of the difference in number of claims and total amount paid out between the relevant years for analysis in **Figures 4 and 5**. A 56 percent decrease in the total amount paid out through the Program from 2017 to 2018 for both Civilian & Police and Fire and Federally Funded Civilian claims was observed. The City should perform year over year analyses for claims data to identify anomalies or red flags of FWA.

When further comparing the change in claims year to year, Civilian and Police & Fire data shows certain departments have approximately the same number of claims filed each year, but the overall amount paid out is much higher in one versus the other (**Figure 6**).



**Figure 4. Claims by Year for Civilian and Police and Fire**

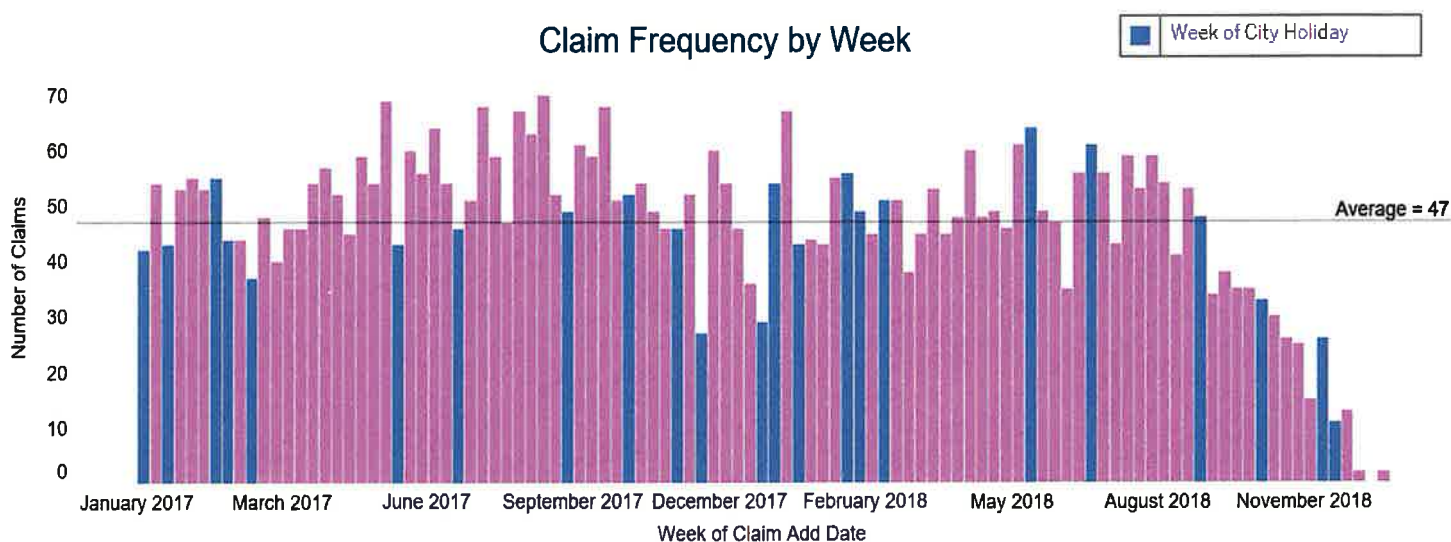


**Figure 5. Claims by Year for Federally Funded Civilians**



### Timeframe Analysis

Analyzing claim frequency relative to the calendar year reveals spikes in claims that correspond to the week of or immediately following a holiday recognized by the City, as stated on the City's website (**Figure 7**). A high number of claims immediately following a holiday could be considered anomalous, outside of work injuries and is often indicative of FWA in workers' compensation claims. Grant Thornton recommends the City implement controls within the Program specifically targeting the weeks of and following holidays, to identify spikes in the number of claims filed during those weeks as compared to the average. A week of claims that tracks above the average may indicate that further review of claims opened in those weeks is appropriate.

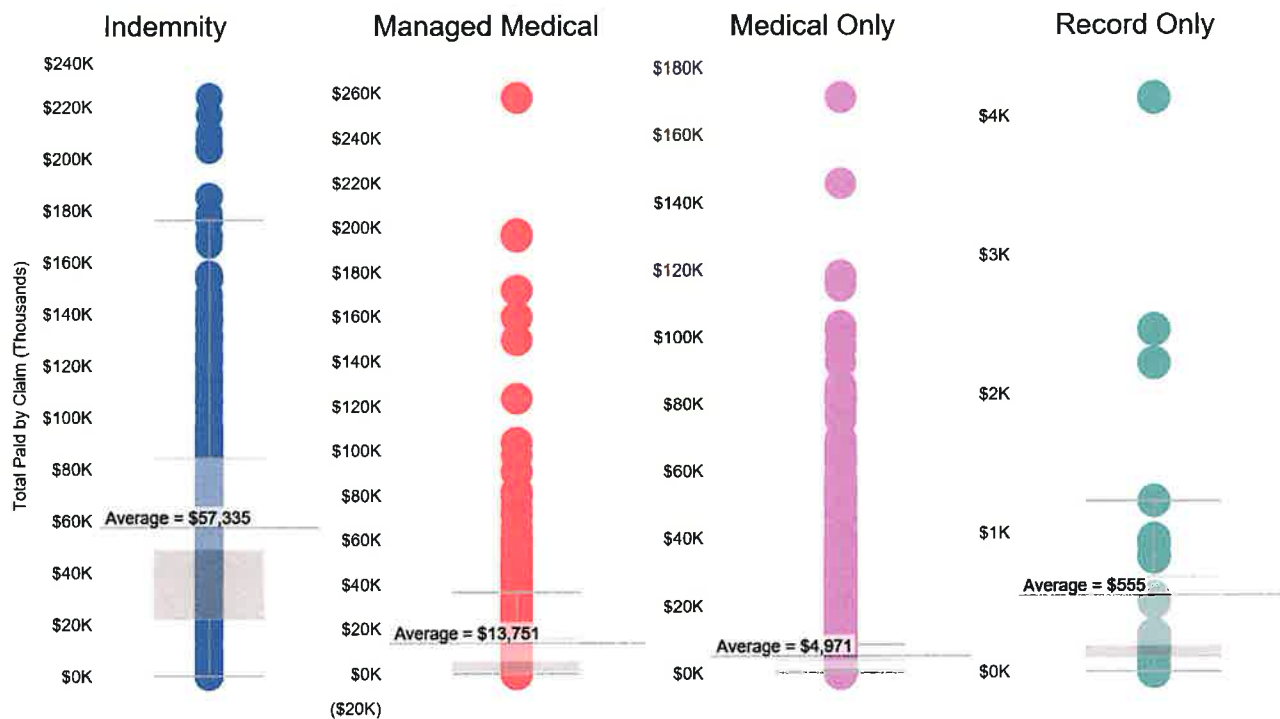


**Figure 7. Claims Opened by Week for Civilian and Police and Fire**

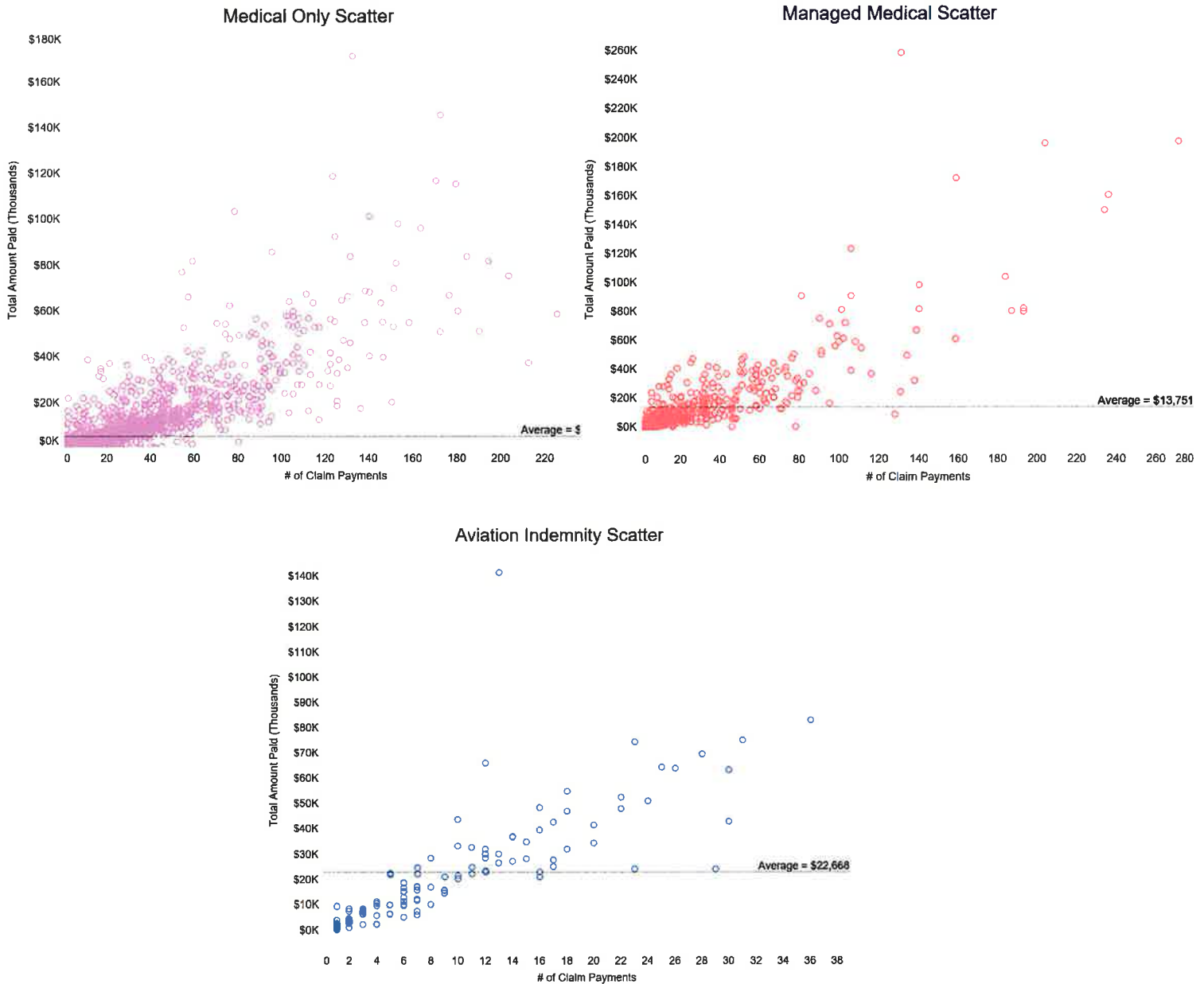


### Payments Analysis

We performed a boxplot analysis (see **Figure 8**) for each claim type, identifying an individual claim's percentile ranking, measured by the total amount in dollars paid by claim. We recommend claims with a total amount above the 75<sup>th</sup> percentile be considered for further review. Due to the large number of claims ranked above the 75<sup>th</sup> percentile for Managed Medical and Medical Only claim types, for Civilian and Police & Fire claims, as well as, Indemnity claim types for Aviation claims, Grant Thornton further analyzed these claim types with scatterplots, as in **Figure 9**.



**Figure 8. Total Payments by Claim Type for Civilian and Police and Fire**



**Figure 9. Civilian and Police & Fire Medical Only, Civilian and Police and Fire Managed Medical, and Aviation Indemnity Scatterplots**



The scatterplot analysis reveals a majority of claims for both Managed Medical and Medical Only types are clustered around smaller total payments relative to their respective averages. Analyzing claims via scatterplot allowed Grant Thornton to identify additional outliers observed for both Managed Medical and Medical Only claims.

Grant Thornton recommends, where possible, the City develop visualizations to track claim payments and detect potential outliers. Outliers within claim payment analysis should be considered for review because they could potentially identify instances of overpayment, exaggerated injury, and other such suspicious scenarios.

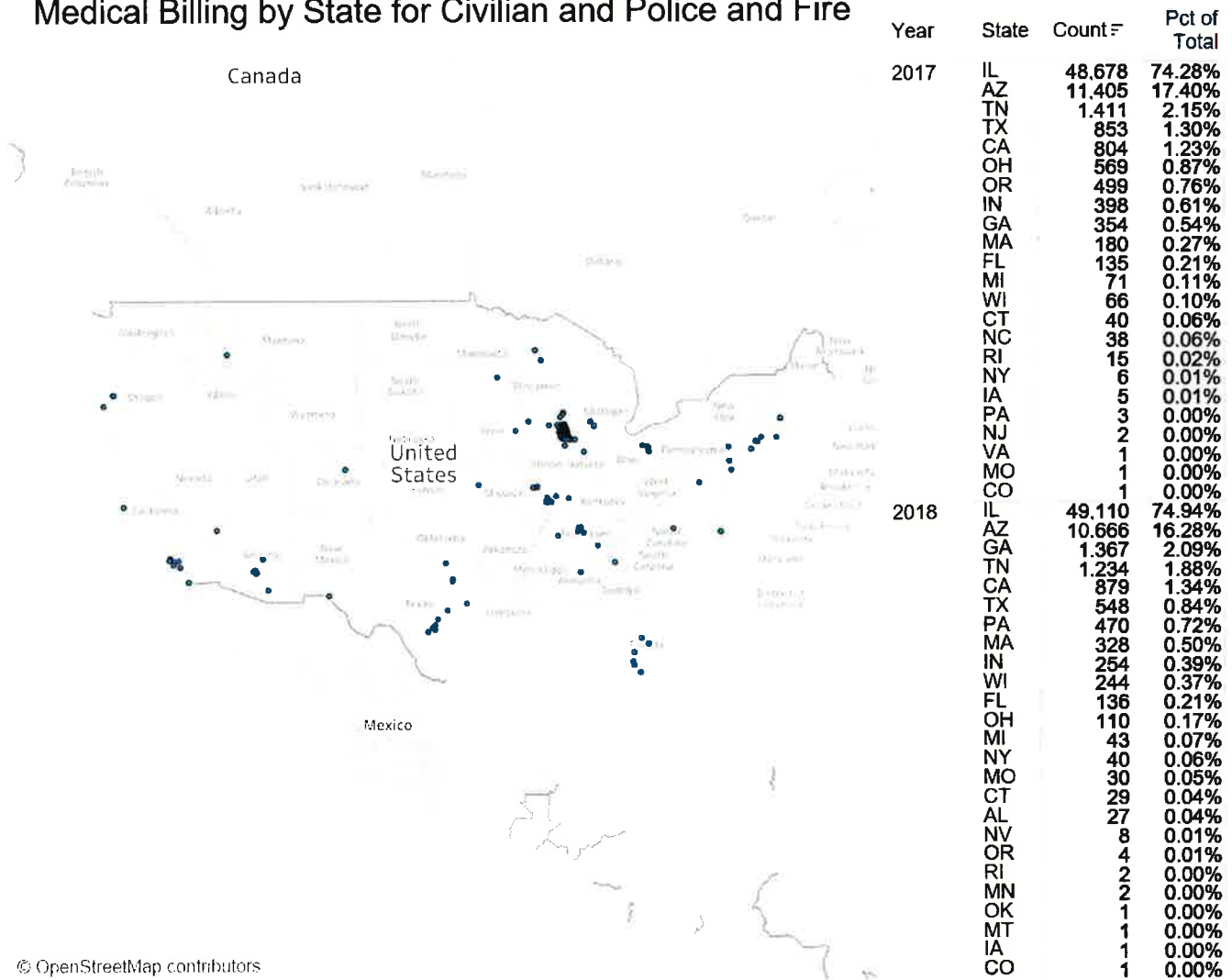
#### Geospatial Analysis

Grant Thornton performed a geospatial analysis of payments made to medical providers through the Program (see **Figure 10**). Through this analysis we observed over 25 percent of all payments made to medical providers were billed by providers outside of the State of Illinois. This high level is due in part to the Program's preferred medical prescription company encompassing over 98 percent of payments made to providers in the State of Arizona. However, adjusting to exclude Arizona from the analysis, providers outside of Illinois still accounted for roughly 10 percent of bills paid to medical providers. This geographic makeup of payments to medical providers is consistent across 2017 and 2018.

Payments to providers with billing addresses outside of the State of Illinois should be considered for further review. Grant Thornton suggests a system control be created within the Program when a new provider is added with a billing address outside of the State of Illinois.



## Medical Billing by State for Civilian and Police and Fire



**Figure 10. Medical Providers by State for Civilian and Police and Fire**

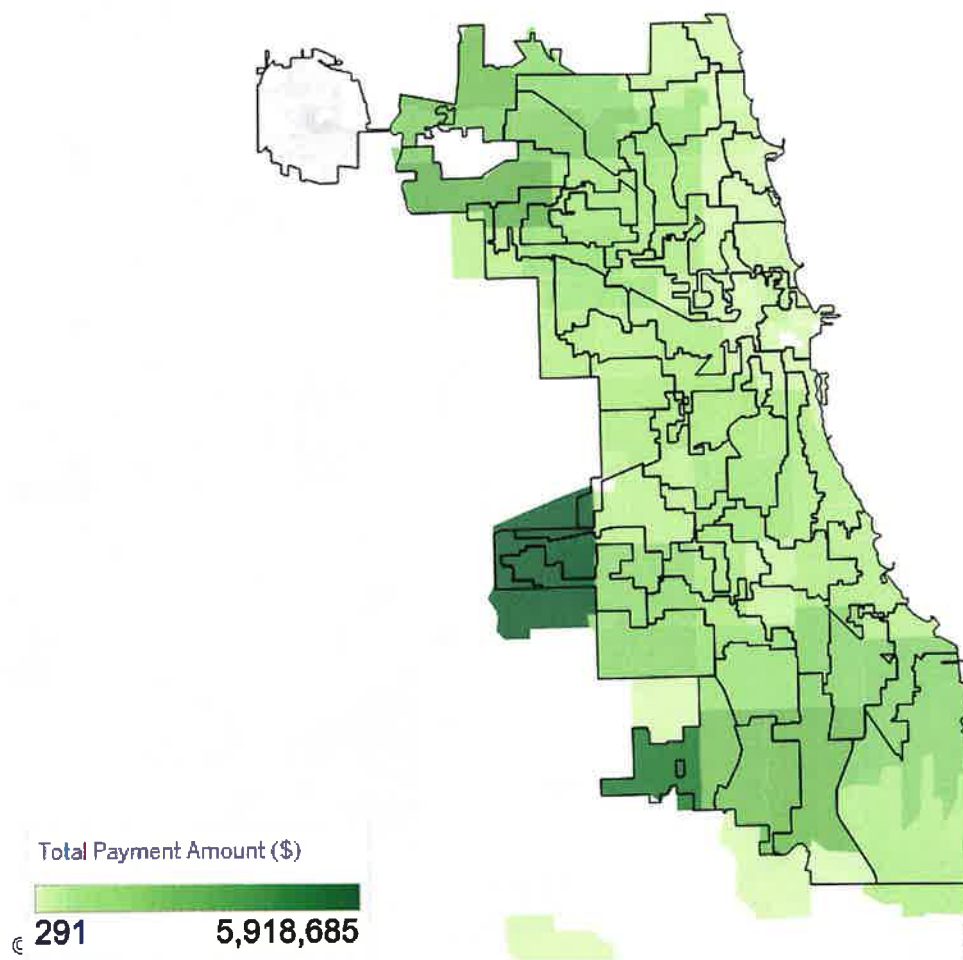
Grant Thornton performed a separate geospatial analysis to review the total value of claim payments made for claimants residing in the same zip code. Grant Thornton combined this analysis with the City's Ward boundary data from the City's Data Portal to provide a relative reference of Wards associated with high claim payment zip codes. Grant Thornton observed for claims in the relevant time frame, the highest payments were made between three geographic clusters in the City: southern region (Ward 19), southwestern region (Wards 13, 14, 22, and 23), and northwestern region (Wards 29, 30, 36, 38, 39, and 45) (see **Figure 11**). For a detailed map of City Ward boundaries, see **Appendix H**. The southwestern region of the City receives the most claims for Civilian, Police and Fire, and Aviation claims. This is highlighted in **Figures 12, 13, and 14** for Civilian, Police and Fire, and Aviation





claims, respectively. Further review of claims filed by claimants residing in these areas should be considered as the clusters could be indicative of a trend or a potential scheme amongst individuals living in the same area.

## Aviation, Civilian, and Police and Fire Claims Geospatial Analysis

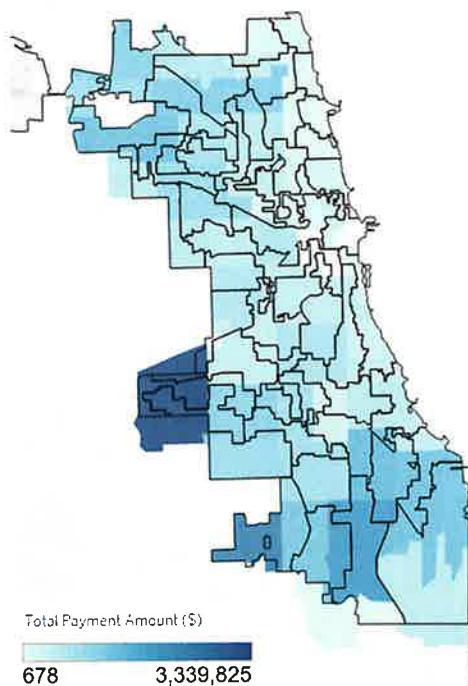


**Figure 11. Aggregate Geospatial Analysis**

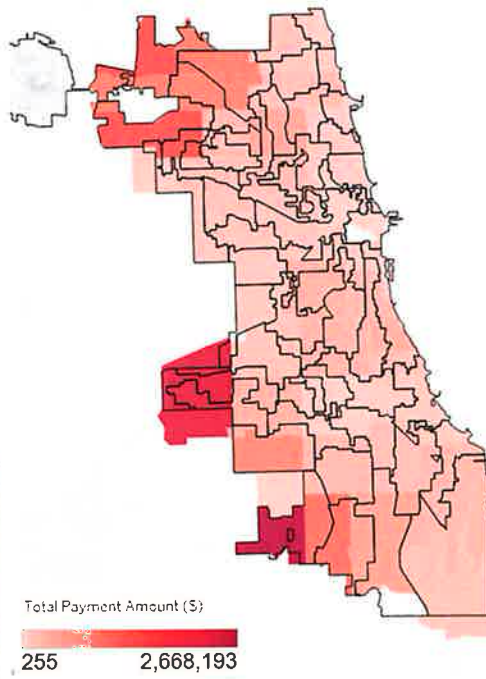
We performed further analysis on geographic claim distribution as compared to City employee residential locations to understand whether any unusual correlations about claim distribution could be observed (see **Appendix J**). Grant Thornton noted geographic claim distribution and city employee residential locations generally correlated, and we did not observe notable outliers.



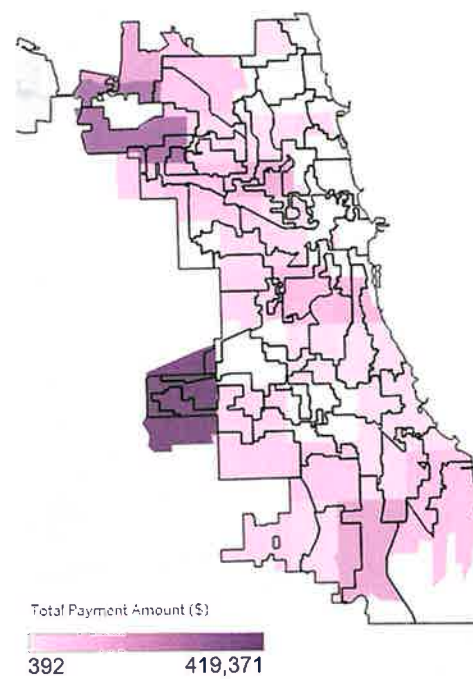
Civilian Total Claim Payments

**Figure 12. Civilian Geospatial Analysis**

Police and Fire Total Claim Payments

**Figure 13. Police and Fire Geospatial Analysis**

Aviation Total Claim Payments

**Figure 14. Aviation Geospatial Analysis**

*Note: Employee Zip Code Data for Federally Funded Civilian claims was not provided, therefore, a geospatial analysis could not be completed.*

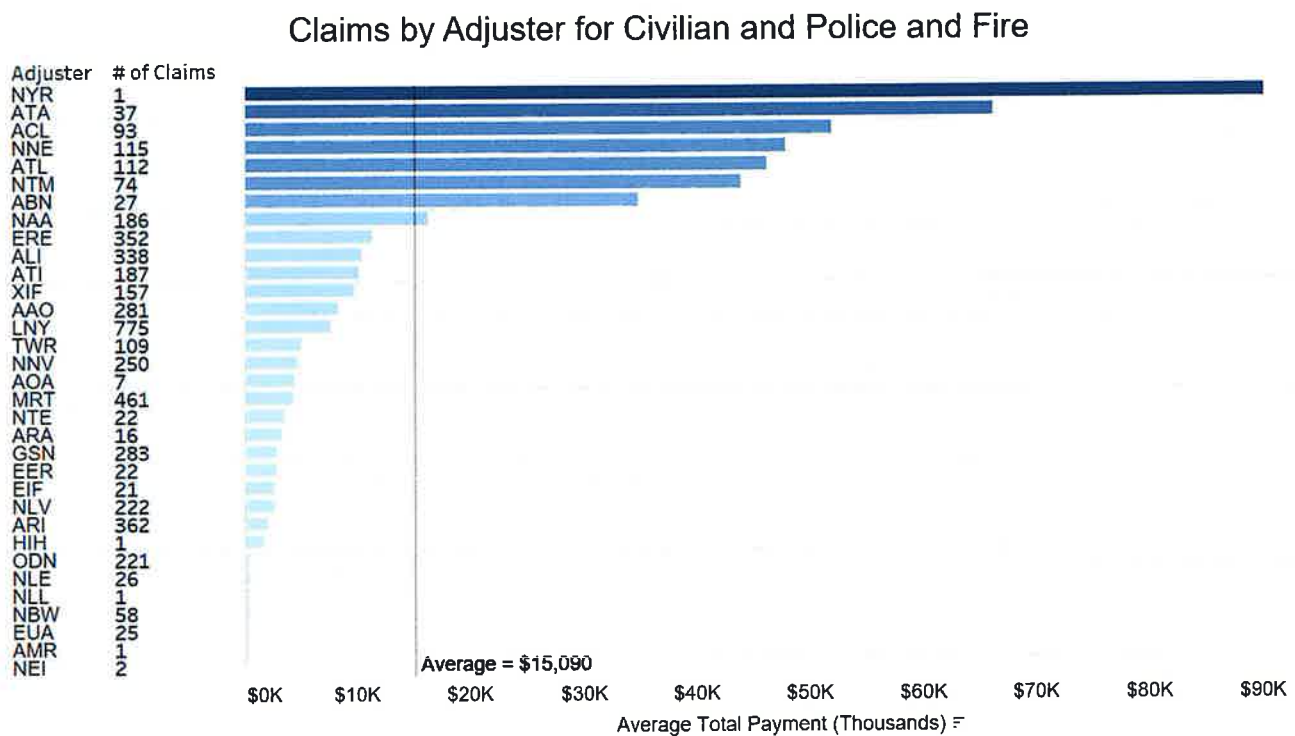
### Adjuster Analysis

The average total amount paid per claim across Program claim adjusters for Civilian and Police and Fire claims is \$15,090. Comparing each Civilian and Police and Fire adjuster's individual average amount paid to the overall average identifies several individuals whose average payout per claim is above average (see **Figure 15**). Similar analyses were completed for Aviation claims, but no similar outliers were identified. Grant Thornton performed an identical, but more granular analysis to analyze average claim payment by adjuster by claim type. Through this analysis, we identified several Record Only claims with one or more payments; however, Record Only claims generally should not have associated benefit payments (see **Figure 16**). This analysis can assist in identifying adjusters with a potential misunderstanding of the payments requirements as defined by the Program, adjusters with inadequate training or attention to detail, or other suspicious behavior.

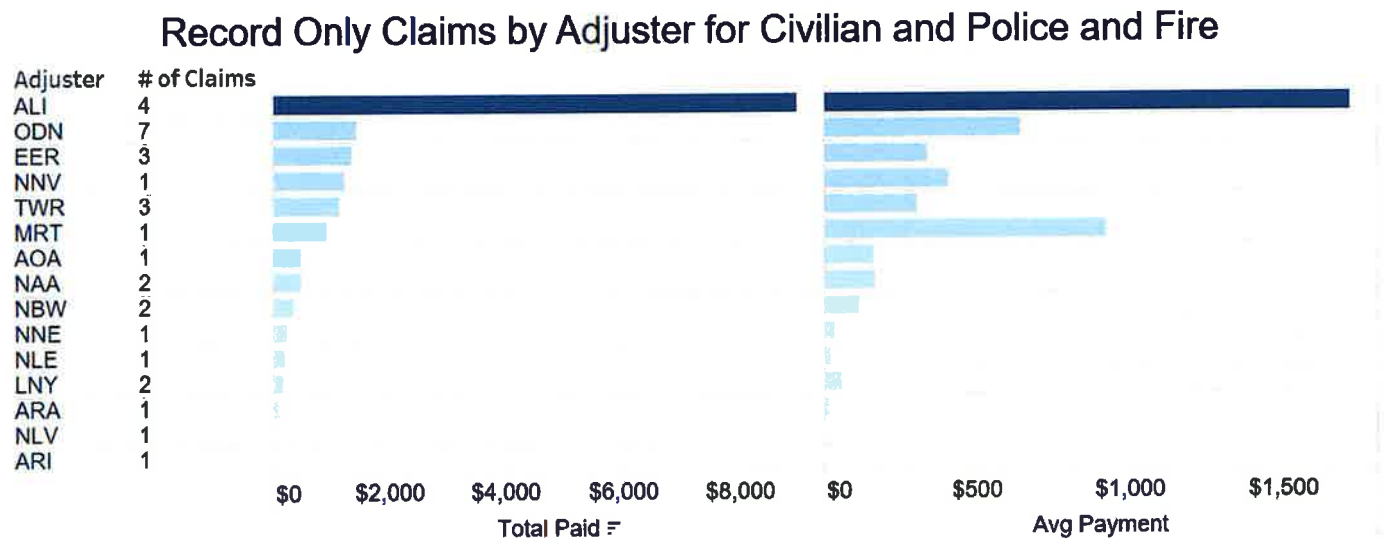
Record Only claims paid out by an adjuster may indicate an adjuster's misunderstanding of the payment requirements as defined by the Program. Grant Thornton suggests that the City develop



system checks within the Program that indicate when a payment has been made for a Record Only claim (see **Figure 16**).



**Figure 15. Average Total Amount Paid per Claim for all Program Adjusters**



**Figure 16. Record Only Claims Paid**

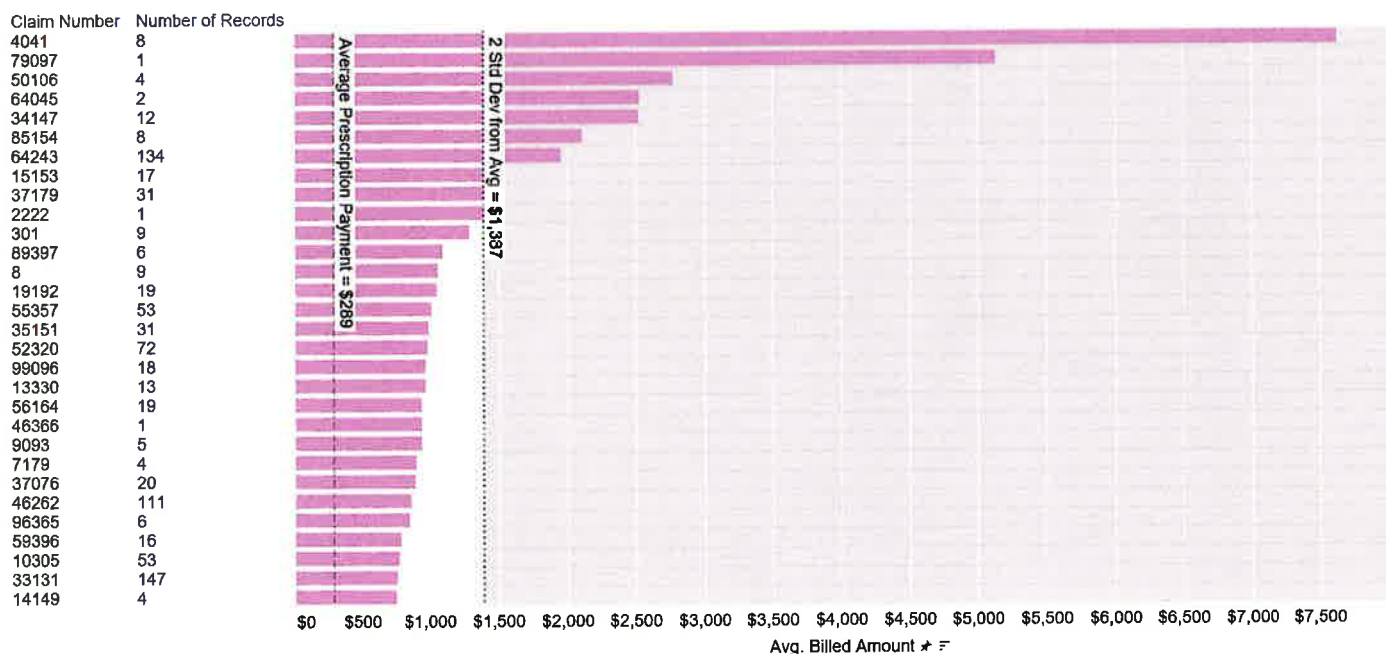


### Prescription Analysis

Grant Thornton calculated the average value of prescription payments and procedure payments per claim was \$289 and \$321, respectively, for Civilian and Police and Fire claims. We conducted an outlier analysis for both types of payments, identifying claims that were more than two standard deviations away from the average<sup>8</sup>. As shown in **Figures 17 and 18** below, there were numerous claims which stand out as outliers in regard to average prescription and procedure payment, as shaded in gray. Grant Thornton was unable to perform similar analyses for Aviation and Federally Funded Civilian claims as the medical billing data through CCMSI was unavailable for review.

Prescriptions and procedures billed for an amount greater than two standard deviations above the average could indicate inflation of costs by providers or over-prescription of medications to claimants. Grant Thornton recommends the City put process controls in place to periodically test for outlier claims with prescriptions and procedures bill amounts that exceed recent billed amounts (e.g., average billed amounts over last two years) and consider further review into the claims associated with these bills.

## Prescription Payment Outliers for Civilian and Police and Fire



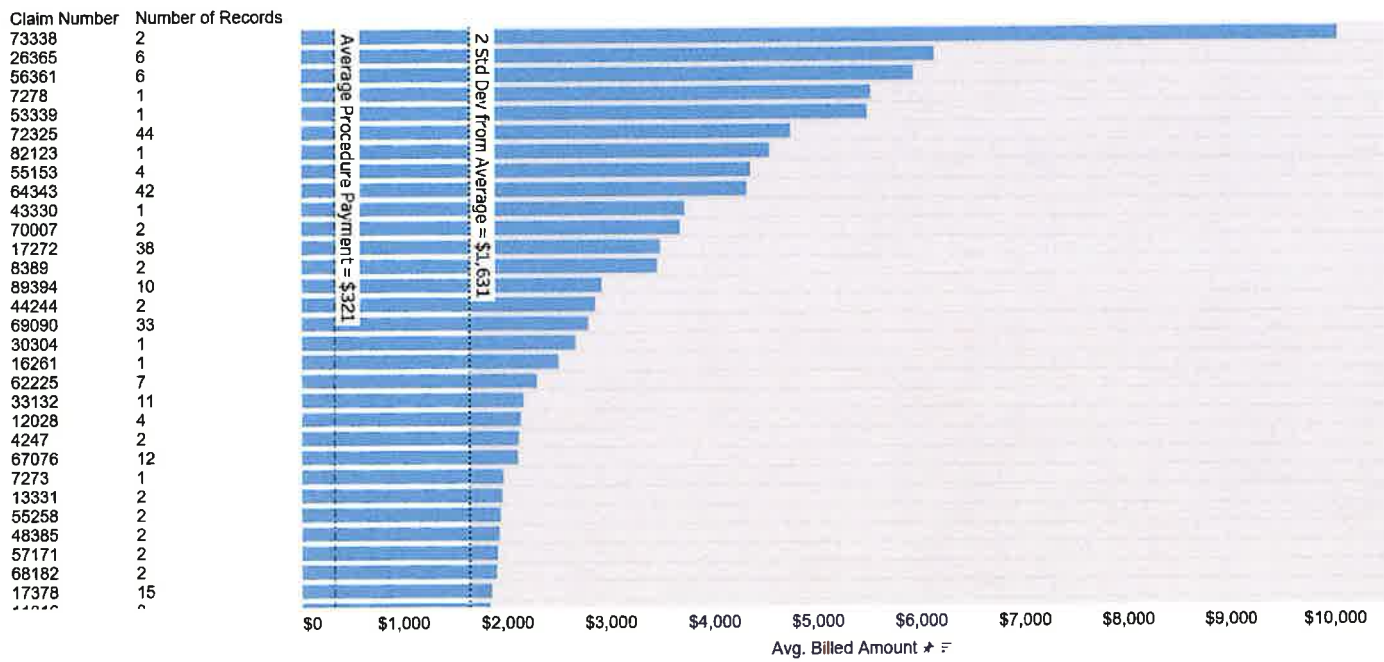
**Figure 17. Prescription Billing for Civilian and Police and Fire**

<sup>8</sup> The statistical definition of an outlier is any record that lies greater than two standard deviations away from the mean.





## Procedure Payment Outliers for Civilian and Police and Fire



**Figure 18. Procedure Billing for Civilian and Police and Fire**

### Legal Spend

Through conversations with the City and Program personnel, Grant Thornton learned that Hennessy & Roach, P.C. (“Hennessy & Roach”) was the law firm most frequently referred workers’ compensation claim legal support by the Program; however, this only represents a small portion of all claims requiring legal support. After reviewing the claims year detail of those claims referred to Hennessy & Roach, Grant Thornton identified 23 claims filed prior to 2013 for which the related case was opened by Hennessy & Roach between 2017 and 2018 (see **Figure 19**). Based upon the documentation made available to us, it is unclear as to the amount and duration of any legal support for those 23 claims. (Note: Of the external law firms used by the Program we requested data from through Counsel, Hennessy & Roach was the only firm to provide data to be analyzed.) In addition to recommendations identified in **Section VI.d.** for developing a bidding process for identifying approved third parties, the City should consider developing an approved list of external law firms to which the Program can refer claims for legal support. Additionally, the City should develop a framework for identifying applicable criteria for when claims are referred externally for legal support versus to the DOL Torts Division.





## Hennessy & Roach Lawsuits for Claims Opened Before 2013

Employee Zip Code	Claim Year	# of Claims	Total of Associated Claims Paid
60617	2008	1	\$116,080
	2011	1	\$119,998
	2012	1	\$36,656
60634	2012	1	\$224,048
60609	2004	1	\$107,282
	2010	1	\$103,619
	2011	1	\$10,805
60638	2005	1	\$90,812
	2009	1	\$130,763
60612	2012	1	\$204,855
60631	2010	1	\$159,883
60608	2012	2	\$150,443
60616	2012	1	\$126,335
60643	2006	1	\$94,294
	2012	2	\$20,573
60636	2012	1	\$92,357
60622	2008	1	\$82,878
60656	2009	1	\$80,463
60652	2008	1	\$15,347
60633	2011	1	\$627
60640	2011	1	\$0

**Figure 19. Hennessy & Roach Lawsuits for Claims Greater Than Five Years Old**

### d. Recommendations

Based on the analyses completed, Grant Thornton identified several instances of anomalous patterns. Grant Thornton recommends the City and the Program perform standard and consistent monitoring and tracking of claims in alignment with the above analyses. These monitoring and tracking processes should be completed immediately after data is pulled from iVOS and aggregated with other data available (e.g., CCMSI and Coventry data). More robust analyses of the available data is called for in order to identify claims for further review. Examples of these analyses include routine statistical reporting, outlier alert notifications, and visualizations. Generating summary statistics monthly or quarterly for each claim type would allow Program personnel to validate how the claims within iVOS are tracking against expectations. A large jump in the average amount paid out on a number of claims or for one claim type from one calendar quarter to the next could indicate overpayments may have occurred. Developing alerts for figures associated with claim payments greater than two standard deviations above average can allow Program personnel to identify claims that may need further review.

Grant Thornton encourages the City to consider using analyses similar to the examples provided in our findings as methods of highlighting areas where anomalous claim patterns from 2017 and 2018 have been identified. Grant Thornton recognizes that the City's ability to replicate these analyses may be limited due to their lack of access to software similar to those used by Grant Thornton. Grant Thornton believes development and consistent processing of similar analyses in the form of reports and system controls will aid the City in its efforts to identify potential instances of FWA in the Program.

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## VII. CLAIMS TESTING

### a. Workstream Summary

Grant Thornton tested 109 claims on a sample basis, made up of both judgmentally and randomly selected samples. We tested these claims against several attributes that aligned to the Program's Claims Management Guide, rules and regulations promulgated by the Act, workers' compensation insurance industry recognized best practices, and where applicable, processes and procedures in place at CCMSI. All 84 Civilian and Police and Fire claims tested – administered by the Program – failed at least three (3) attributes (i.e., failed the test). Otherwise stated, 100 percent of the Civilian and Police and Fire claims tested failed at least three (3) attributes of our testing. Of the 25 claims administered by CCMSI we tested, seven (7) claims passed all of the attributes in our testing. Otherwise stated, 72 percent of the remaining 18 CCMSI claims we tested failed at least one (1) attribute of our testing. Six (6) of the 25 CCMSI-administered, or 33 percent, failed at least three (3) attributes. (See **Appendices B – E** for our testing attributes by claim type.)

Grant Thornton identified three broad areas for improvement that may lead to more robust claims administration: (1) developing thoroughly documented policies and procedures that encompass the entire claim administration process and include monitoring and oversight mechanisms, (2) instituting a formalized training regimen for all Program employees, and (3) performing a continual assessment of the systems, protocols, and inter-departmental communication channels for operational effectiveness and efficiency to support the Program's ultimate goal of returning employees to work as quickly and safely as possible.

While the financial impact of implementing these three areas of improvement may initially appear cost prohibitive, the long term financial and operational benefits would be greater than the initial resource investment. Alternatively, the City should consider if maximum benefits would be achieved by outsourcing the Program's administration of workers' compensation benefits to a third party that specializes in the administration of workers' compensation benefits.

### b. Procedures Performed

To understand the Program's claims administration process, procedures, and systems, Grant Thornton conducted interviews with key process owners, DOL Torts Division attorneys, and external legal counsel (Hennessy & Roach). We performed our testing procedures based on information gathered through the interviews along with information contained in the Claims Management Guide (which the Program considers 'best practices'), and the Police and Fire CBAs.

As of the date of this report, the City's Program uses iVOS to administer Civilian and Police and Fire claims. iVOS enables the Program to conduct and track claims management, policy administration, case management, events management, and claim payments. Coventry provides bill and UR services to the Program for both Civilian and Police and Fire claims; claimant medical records and medical bills are maintained within the Coventry Connect system. Program management provided Grant Thornton with a walkthrough of how a claim is processed within iVOS and how Program management monitors claims. CCMSI administers Aviation and Federally Funded Civilian claims using its claims management system, Internet Claims Edge ("ICE"). Grant Thornton requested, and was given access to iVOS, Coventry Connect, and ICE to perform claims testing.



Grant Thornton requested and received all Civilian and Police and Fire claims data for calendar years 2017 and 2018. Similar data was requested and received from CCMSI for Aviation and Federally Funded Civilian claims. We then stratified the claims data received into six distinct claims categories:

1. Indemnity
2. Life Reserves
3. Managed Medical
4. Medical Only
5. Pending
6. Record Only

During our scope period of testing, the claim category counts were:

*Civilian* – 400 Indemnity claims, two (2) Life Reserve claims, 608 Managed Medical claims, 1,598 Medical Only claims, four (4) Pending claims, and 485 Record Only claims

*Police and Fire* – 42 Managed Medical claims, 6,418 Medical Only claims, 10 Pending claims, and 288 Record Only claims

*Aviation* – 169 Indemnity claims, 154 Medical Only claims, and 92 Record Only<sup>9</sup> claims

*Federally Funded Civilian* - 17 Indemnity claims, 33 Medical Only claims, and nine (9) Record Only claims

Grant Thornton also considered other qualitative characteristics for selecting claims to test such as: claims referred by the OIG for further investigation, claims referred to external legal counsel for legal proceedings, claims with a large reserve and/or benefits paid amount as of the date of testing, active claims open for extended periods of times, and closed claims with substantial payments (i.e., above \$1,500) after the claim was closed.

Grant Thornton tested 109 claims comprised of the following: 59 Civilian, 25 Police and Fire, 20 Aviation, and five (5) Federally Funded Civilian. We then analyzed the selected claims in iVOS, ICE, and Coventry Connect for a combination of performance attributes, which varied by claim type. For example, Indemnity claims may be reviewed for completeness and accuracy of retaining and recording litigation matters within iVOS, whereas a Record Only claim may only be reviewed for appropriate file administration and timely closure. Performance attributes were identified within the testing matrix as federal law, State law, City law/ordinance, Program policies/procedures, and workers' compensation insurance industry recognized best practices (see **Appendices B – E**). Claims administered on behalf of the Police and Fire departments had specific performance attributes due to requirements instituted by their respective CBAs. There were specific performance attributes for CCMSI's administration of Aviation and Federally Funded Civilian claims.

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<sup>9</sup> CCMSI classifies Record Only claims as Incident Only.



### c. Findings

The content below presents testing results on a summary level by testing attribute. Refer to (**Appendices B – E**) for a detailed count of all claims testing results. Not all attributes applied to all claims tested due in part, but not limited to, the nature of the claims (Medical Only, Indemnity, etc.), disposition of the claim (approved, denied, etc.), whether a given claim was litigated, whether the claim was still open at time of testing, and other qualifying characteristics. The summary results presented herein indicate how many claims the subject attribute applied to for all claims tested.

#### Civilian and Police & Fire Claims

##### **File Administration**

The Program's Claims Management Guide states a Program supervisor should review all new claims and related initial claim data when received to make an initial compensability assessment. Of the 57 Civilian and 25 Police and Fire claims to which this attribute applied, we identified 56 Civilian claim and 24 Police and Fire claim where a Program supervisor's review was not documented.

It is commonly accepted workers' compensation insurance industry best practice to assign a claim to an adjuster within 24 hours of the claim having been received (in this case, by the Program) to expedite claim processing and ensure timely completion of subsequent steps after claim intake. This testing attribute applied to all 84 Civilian and Police and Fire claims we tested. Of these, there were 51 Civilian claims which were not assigned to a Program adjuster within 24 hours.

The Program's Claim's Management Guide stipulates the claimant's AWW and TTD benefit amounts should be calculated within two (2) days of the claim being assigned to a Program adjuster. Of the 37 Civilian claims to which this attribute applied, seven (7) claims did not have their AWW and TTD benefit amounts calculated within the two (2) day requirement.

##### **Initial File Review**

The Program's Claims Management Guide states an initial file analysis ("IFA") should be conducted upon claim assignment to a Program adjuster. Grant Thornton tested IFA documentation against commonly accepted workers' compensation insurance industry best practices that generally allow 24 to 48 hours after the claim is assigned to a Program adjuster for such a review. This attribute applied to all 84 Civilian and Police and Fire claims tested. The timely IFA was not documented for 53 Civilian and 19 Police and Fire claims.

The Program's Claims Management Guide states a recorded statement should be obtained from all claimants. Of the 81<sup>10</sup> claims to which this attribute applied, 13 Civilian and all 24 Police and Fire claims did not contain a recorded claimant statement. As the Police and Fire departments' administration of their

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<sup>10</sup> One (1) Police and Fire claim and one (1) Civilian claim were death claims, and one (1) Civilian claimant was "incapable" of providing a recorded statement, and thus the recorded statement would not apply.





respective claims before the claims are transferred to the Program was outside of the scope of our engagement, it is unknown if Police and Fire claims require a recorded statement; however, an investigation would be incomplete without a statement being obtained and documented.

The Program's Claims Management Guide contains a best practice to obtain a witness statement on all Medical Only, Indemnity, and Managed Medical claims. Of the 50 claims tested to which this attribute applied, 20 of the Civilian and eight (8) of the Police and Fire claims did not contain a witness statement.

The Claims Management Guide contains a best practice that an Action Plan/Summary should be documented in iVOS. The best practice further stipulates a Program supervisor should have executed and review a Notepad<sup>11</sup> report for Action Plan/Summary at mid-month for a prior month's claims and mid-week for a prior week's claims. Of the 84 Civilian and Police and Fire claims to which this attribute applied, 22 Civilian and 17 Police and Fire claims did not contain an Action Plan/Summary. The lack of this step being taken indicates not only the Program adjusters' failure to create an Action Plan/Summary, but also the Program supervisor's failure to conduct a thorough periodic review of Action Plan/Summaries, if conducted at all. Some claims tested did contain notes with the topic 'Action Plan', however, in many cases there was no actual Action Plan within the content of the notes. An Action Plan should provide a proposed strategy or course of action in moving the claim forward to conclusion. It should also be updated throughout the course of an open claim file.

The Claims Management Guide contains a best practice that compensability determinations be completed and documented within two (2) business days after claim assignment to a Program adjuster. Further, the best practice stipulates a Program supervisor should execute and review a Notepad report for compensability mid-month for a prior month's claims and mid-week for a prior week's claims. Of the 57 Civilian claims to which this attribute applied, 10 claims did not contain documented compensability determination. This lack of documentation indicates not only the Program adjusters' failure to document compensability determinations, but also the Program supervisor's failure to conduct a thorough periodic review of compensability, if conducted at all. Compensability determinations for Police and Fire claims are conducted by those respective departments and we did not have access to Police or Fire Department claim compensability documentation.

## **Benefit Delivery/Wages**

Based on interviews with Program staff, it is the Program's process that Program clerical staff calculate AWW and TTD, and that calculated rates be verified by the assigned Program adjuster. Of the 36 Civilian claims to which this attribute applied, 15 claims did not have a documented AWW verification.

The Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires Temporary Disability stop letters be sent to the claimant within 14 days of benefits being stopped. Of the 27 Civilian claims to which this attribute applied, the Program did not send stop letters to 17 claimants.

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<sup>11</sup> Notepad is a documentation function within the iVOS system used by the Program.





We also identified overpayments totaling \$14,073.02<sup>12</sup> for six (6) of 39 Civilian claims tested to which this attribute applied. All overpayments were related to Indemnity benefits being paid after Indemnity benefits were stopped or because of incorrect calculation of Indemnity benefits.

## **Medical Review**

The Program's Claims Management Guide stipulates a Program adjuster should conduct an initial and ongoing review of available medical records. The best practice further stipulates this should be documented in a Medical Notepad within iVOS and summarized in the Action/Plan Summary Notepad. Of the 77 Civilian and Police and Fire claims to which this attribute applied, 29 Civilian and 23 Police and Fire claims did not contain a documented medical record review.

The Program's Claims Management Guide contains a best practice to obtain a signed medical release (Medical Authorization Request) from the employee. Of the 82 claims to which this attribute applied, 24 Civilian and 24 Police and Fire claims did not have evidence of the medical release being retained or at the very least being initially sent to the claimant.

The Program's Claims Management Guide stipulates a medical canvas for additional records should be conducted and documented in the Medical Notepad and summarized in the Action Plan/Summary Notepad. The Claims Management Guide stipulates beginning March 2015, claims adjusters should be "completing ISO indexing initially and throughout the life of the claim; preferably every six months" – which would include prior claims history for a given claimant. Of the 72 Civilian and Police and Fire claims to which this attribute applied, a medical canvas was not conducted and properly documented for 41 Civilian and 24 Police and Fire claims.

The Program's Claims Management Guide makes reference to the Act's authorization to employers to conduct a drug and alcohol test on employees after they are involved in any incident that results in a fatality or injury occurring while on duty or while performing acts on the behalf of the employer. The Program's best practice per the Program's Claims Management Guide is to record drug and alcohol testing results in the iVOS "Examination Tracking" tab. Of the 75 claims to which this attribute applied, 16 Civilian and 23 Police and Fire claims did not contain drug or alcohol test results.

## **Forms**

The Act requires employers to file First Report of Injury ("FROI") reports (IL Form 45) for all claims resulting in more than three (3) days of lost wages for the employee. Of the 39 tested claims to which this attribute applied, there was no evidence in the file that a FROI was manually filed with the Illinois Worker's Compensation Commission as required under section 6(b) of the Act.

The Illinois Workers' Compensation Commission Title 50, Chapter 6, Part 9110, Section 9110.70 of Joint Committee on Administrative Rules Administrative Code requires that delay letters be sent to the claimant if a compensability decision will not be made within 14 days of being notified or when they are aware of a related liability that will delay compensability determination. Of the 46 claims we tested to which this

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<sup>12</sup> Overpayments ranged from \$80.00 to \$11,416.46, and averaged \$2,345.50.



attribute may have reasonably applied due to adjudication taking more 14 days as noted in the claim file, none (0) contained evidence of a delay letter.

The Illinois Workers' Compensation Commission Title 50, Chapter 6, Part 9110, Section 9110.70 of Joint Committee on Administrative Rules Administrative Code requires that denial letters be sent to claimants within 14 days of being notified or when they are aware of a related liability if the employer denies liability for payment of temporary total compensation with a written explanation of the basis for denial. Of the 16 denied claims we tested, 12 Civilian and two (2) Police and Fire claims failed this attribute test as there was either no denial letter or the reason for denial was vague and provided no denial reason other than "Claim is not compensable".

The Program's Claims Management Guide contains a best practice to document reserves via the Reserving Worksheet in iVOS. Of the 28 Civilian claims to which this attribute applied, only one (1) contained a Reserving Worksheet that contained sufficient reserves to cover bills paid. The other 27 Civilian claims either did not contain a Reserving Worksheet, or if a claim did contain one, it was not sufficiently filled out to support subsequent benefits and medical bills received and paid.

## Reserves

Per the Claims Management Guide, reserves for applicable claims should be set within two (2) business days from when the claim is assigned to a Program adjuster. Of the 83 claims to which this attribute applied, six (6) Civilian and one (1) Police and Fire claim did not have reserves set timely.

It is commonly accepted workers' compensation insurance industry best practice to set reserve exposure for potential ultimate probable cost or expected future indemnity and medical payments. Of the 74 claims to which this attribute applied 11 civilian and 3 police and fire claims contained adequately calculated exposure reserves. 40 Civilian and 20 Police and Fire claims did contain adequately calculated reserves.

Grant Thornton observed it is commonly accepted workers' compensation insurance industry best practice reserves be properly set to pay for future and expected bills associated with the claim, and not on an ad hoc basis, or what is known as "stair-stepping"<sup>13</sup>. According to commonly accepted workers' compensation insurance industry best practices, reserves should be set within two (2) business days. While this was satisfied for most claims due to auto-reserving<sup>14</sup>, reserves were rarely reassessed until medical bills or indemnity payments were due (stair-stepping). Further, if a claim remains open for one (1) year or longer, a reserve reflecting ultimate probable cost should be set. At least one (1) claim tested that was open for longer than one (1) year did not reflect Ultimate Probable Cost reserves. This information is reflected in the results presented above related to reserve exposure setting.

While Grant Thornton did not attempt to quantify the potential stair-stepping effect on the City's financial statements, it should be noted the effect of stair-stepping can result in the improper asset and liability valuation on an organization's financial statements. Not properly setting reserves at the onset of a claim

<sup>13</sup> "Stair-stepping" is the practice of frequently raising claim reserves to cover payments that come due. If loss reserves are raised by increments in order to cover the cost of claims expense as they happen, the term stair-stepping comes into to use. If the claim reserves were to be charted, the resulting graph would look like stair steps.

<sup>14</sup> iVOS automatically reserves \$500 for all claims.



also hinders the Program's ability to identify claims for which investigative and/or legal measures might mitigate the amount of loss. To prevent or minimize stair-stepping from the Program, its management would need more monitoring, training, and oversight to ensure adequate reserve setting at the onset and throughout the life of the claim. While reserves will likely never be 100 percent accurate, they should be set appropriately based on claim facts and progress within 12 months of claim receipt. This is referred to as setting the Ultimate Probable Cost on a claim.

### **Subrogation**

The Claims Management Guide states potential third-party recovery should be assessed for all applicable cases. Of the 11 Civilian claims to which this attribute applied, 10 claims were not properly documented for potential third-party recovery. There were no applicable subrogation cases for Police and Fire claims we tested.

Grant Thornton notes that commonly accepted workers' compensation insurance industry best practices suggest all claims be assessed for potential third-party liability and if identified, perform a liability analysis. Because the Program only assessed the third-party liability potential for one (1) claim we tested, this attribute only applied to that one (1) claim and there was no documented liability analysis for the claim.

Grant Thornton noted commonly accepted workers' compensation insurance industry best practices suggest that any subrogation recovery received be documented and recorded. The applicable Civilian claim discussed above for which third-party recovery potential was addressed in the file, had documented evidence of a recovery received.

### **Litigation**

The Claims Management Guide indicates there should be an initial file analysis performed by counsel upon consideration of counsel assignment to a claim. Of the 25 Civilian claims to which this attribute applied, 24 claims did not have a documented file analysis. There were no applicable Police and Fire claims we tested related to litigation.

The Claims Management Guide states a budget should be developed for potential exposure value and legal expenses for a claim. Of the 23 Civilian claims to which this attribute applied, Grant Thornton was unable to identify any budget documented for potential value exposure or legal expenses. As noted previously, there were no applicable Police and Fire claims we tested related to litigation.

The Claims Management Guide states the Program's Director must authorize any legal settlements. Of the 18 Civilian claims to which this attribute applied, Grant Thornton was unable to identify documented authorization of legal settlements. Additionally, beginning in 2018, DOL Torts Division attorneys must request and obtain Claim Counsel's approval to go to trial or settle any claim greater than \$100,000.00. Experienced DOL Torts Division attorneys do have the authority to move to pre-trial if the claim is less than \$50,000.00, while novice DOL Torts Division attorneys must submit detailed written memos to Claims Counsel to obtain approval to go to trial on any given claim.

### **Closure**

The Claims Management Guide sets out timing standards in terms of the initial claims handling, investigation, and closure. Best practices in the guide state within two (2) days of claim assignment,



initiation of contacts, action plan/summary, and initial claim set-up should all be addressed within iVOS. The presence of all of these elements occurring for a claim in the guide's prescribed timeframe would constitute an "aggressively" handled file. We determined that for the 82 claims we tested to which this attribute applied, 44 Civilian and 22 Police and Fire claims were not handled in accordance with the Claims Management Guide.

The Claims Management Guide sets forth best practice standards for on-going bill monitoring, payment, and monthly tracking. These stipulations should ensure that all bills are paid prior to a claim file being closed; and if bills do arise after a claim is closed, they should be minimal and sparse. Of the 50 claims we tested that were closed and to which this attribute applied, 13 Civilian and six (6) Police and Fire claims were not handled in accordance with the aforementioned best practices.

A timely closure process should occur for all claims as indicated throughout the Claims Management Guide. Of the 67 claims we tested to which this attribute applied, 33 Civilian and 13 Police and Fire claims were not closed timely. Based on commonly accepted workers' compensation insurance industry best practices, this would generally be within 30 days after the last reasonably expected benefit liability is paid.

### **Miscellaneous**

As stated in the in the Claims Management Guide, the goal of disability management is to return employees to work in a timely manner. Of the 31 Civilian claims we tested to which this attribute applied, 16 did not have return to work properly documented and addressed. We did not test this attribute for Police and Fire claims as this aspect of claim administration is handled by their respective departments.

Per the Claims Management Guide, the topic of a Special Investigation Unit (SIU) is addressed. It states the SIU should be considered throughout the claim process, from point of intake through closure. Of the 19 Civilian we tested to which this attribute reasonably applied, based on program staff notes and correspondence, six (6) did not address or document SIU involvement. There were no applicable Police and Fire claims we tested involving the SIU.

It is commonly accepted workers' compensation insurance industry best practice that a review for Medicare coverage of eligible claimants should be conducted. All 35<sup>15</sup> claims to which this attribute applied accounted for Medicare eligibility verification.

The Claims Management Guide states as a best practice, thorough and completed diaries<sup>16</sup> are critical to claims administration. Of the 84 Civilian and Police and Fire claims we tested, 21 Civilian and six (6) Police and Fire claims did not have accurate and complete diaries.

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<sup>15</sup> Medicare does not apply to Medical Only claims as settlements do not take place for Medical Only claims. As such, there is no requirement to protect Medicare's interest where no settlement has taken place.

<sup>16</sup> A 'diary' is the documentation of completion of a given claim management step. For example, the adjuster should document the claimant's next medical appointment in a diary as a reminder to follow up on work status, next steps, prepare for bill payment, and evaluate continuation of benefits.





## **Aviation Claims**

### **File Administration**

The Program's Client Service Instructions ("CSI") the City has filed with CCMSI indicates all claims and initial claim data should be reviewed by a CCMSI supervisor when a new claim is received to make an initial compensability assessment. Of the 19 Aviation claims we tested to which this attribute applied, supervisor review documentation was in all of the claim files.

As previously noted, it is commonly accepted workers' compensation insurance industry best practice to assign a claim to an adjuster within 24 business hours of the claim having been received to expedite claim processing and ensure timely completion of subsequent steps after claim intake. This testing attribute applied to all 20 Aviation claims we tested and all were assigned to an adjuster within 24 hours. However, it should be noted that Grant Thornton identified seven (7) Aviation claims that were not reported to CCMSI by the Aviation department in a timely fashion.

While the Program's Claim's Management Guide does not govern CCMSI's practices, for testing comparability purposes we applied the guide's stipulations against the claims handled by CCMSI that were subject to our testing. As stipulated by the guide, the claimant's AWW and TTD benefit amounts should be calculated within two (2) days of the claim being assigned to a claim adjuster. Of the 12 Aviation claims we tested to which this attribute applied, all had AWW/TTD calculated timely.

### **Initial File Review**

The Program's Claims Management Guide contains best practices to conduct an IFA upon claim assignment. Grant Thornton tested IFA documentation against commonly accepted workers' compensation insurance industry best practices that generally allow 24 to 48 hours after the claim is assigned to an adjuster for such a review. This attribute applied to all 20 Aviation claims tested. The timely IFA was documented for all 20 Aviation claims tested.

The Claims Management Guide contains a best practice to obtain a recorded statement from all claimants. Of the 19 Aviation claims we tested to which this attribute applied, three (3) did not contain a recorded claimant statement.

The Claims Management Guide contains a best practice to obtain a witness statement on all Medical Only, Indemnity, and Managed Medical claims. Of the eight (8) Aviation claims we tested to which this attribute applied, five (5) claims did not contain a witness statement.

The Claims Management Guide contains a best practice that an Action Plan/Summary should be documented. Of the 19 Aviation claims tested to which this attribute applied, all contained a documented Action Plan/Summary and subsequent supervisory reviews.



The Claims Management Guide contains a best practice that compensability determinations be complete and documented within two (2) business days after claim assignment to an adjuster. Of the 19 Aviation claims to which this attribute applied we tested, three (3) claims did not contain a documented compensability determination. For the 16 claims where compensability was documented, it was done so in a timely fashion.

### **Benefit Delivery/Wages**

It is the Program's process that the assigned claims adjuster calculates AWW and TTD, and verifies the calculation against the claimant's wage statement. Of the 12 Aviation claims we tested to which this attribute applied, one (1) did not have documented AWW verification.

The Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that Temporary Disability stop letters be sent to the claimant within 14 days of benefits being stopped. Of the five (5) Aviation claims we tested to which this attribute applied, CCMSI did not send Temporary Disability stop letters to any of those claimants.

We did not identify any overpayments for the 20 Aviation claims we tested to which this attribute applied.

### **Medical Review**

The Program's Claims Management Guide stipulates the claim adjuster should conduct an initial and ongoing review of available medical records. The best practice further stipulates this should be documented and summarized. All 16 Aviation claims to which this attribute applied contained a documented medical review.

The Program's Claims Management Guide contains a best practice to obtain a signed medical release (Medical Authorization Request) from the employee. Of the 16 Aviation claims to which this attribute applied, four (4) claims did not have evidence of this medical release being retained or at the very least being sent out to the claimant.

The Program's Claims Management Guide stipulates a medical canvas for additional records should be conducted, documented, and summarized. Of the 14 Aviation claims to which this attribute applied, a medical canvas was not conducted and properly documented for two (2) claims.

The Program's Claims Management Guide makes reference to the Illinois Worker's Compensation Act's authorization to employers to conduct a drug and alcohol test on employees after they are involved in any incident that results in a fatality or injury and occurs while on duty or while performing acts on the behalf of the employer. Of the 11 Aviation to which this attribute applied, four (4) claims did not contain drug test results. One (1) of those four (4) claims that did not contain drug test results, did contain evidence a drug test was performed, but the results were not documented in the claim file.





## **Forms**

The Act requires employers to file FROI reports for all claims resulting in more than three (3) days of lost wages for the employee. Of the 16 Aviation claims we tested to which this attribute applied, all contained evidence in the file that a FROI was manually filed with the Illinois Worker's Compensation Commission as required under Section 6(b) of the Act.

The Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that delay letters be sent to the claimant if a compensability decision will not be made within 14 days of being notified or when they are aware of a related liability that will delay compensability determination. Of the two (2) Aviation claims we tested to which this attribute may have reasonably applied, neither contained evidence of a delay letter.

The Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that denial letters be sent to claimants within 14 days of being notified or when they are aware of a related liability if the employer denies liability for payment of TTD with a written explanation of the basis for denial. Of the two (2) Aviation claims we tested that were denied, both contained documentation of an adequate denial letter being sent to the claimant.

Reserves for claims managed by CCMSI are documented within the tabs of the claim file. As such, the reserves worksheet testing attribute would not have been applicable to these claims. However, Grant Thornton noted that all Aviation claims tested contained documented reserves within the claim files in ICE.

## **Reserves**

It is the Program's best practice that reserves for all applicable claims be set timely, which the Program defines as two (2) business days from claim assignment to an adjuster. Of the 17 Aviation claims to which this attribute applied, all had reserves set timely.

It is commonly accepted workers' compensation insurance industry best practice to set reserve exposure for potential ultimate probable cost or expected future Indemnity and medical payments. Of the 17 Aviation claims we tested to which this attribute applied, all contained adequately calculated reserve exposure.

Grant Thornton observed it is commonly accepted workers' compensation insurance industry best practice that reserves be properly set to pay for future and expected bills associated with a claim, and not on an ad hoc basis or "stair-stepping". According to commonly accepted workers' compensation insurance industry best practices, reserves should be set within two (2) business days. All Aviation claims we tested had reserves adequately set at the onset of a claim and we did not identify a practice of "stair-stepping".

## **Subrogation**

The Program Claims Management Guide contains a best practice that potential third-party liability be assessed for all applicable claims. This attribute applied to all 20 Aviation claims we tested and all addressed subrogation in the claim file.



Commonly accepted workers' compensation insurance industry best practices suggest all claims should be assessed for potential third-party liability and if identified a liability analysis be performed. Of the two (2) Aviation claims for which potential third-party liability was identified, both contained documented liability analysis.

Commonly accepted workers' compensation insurance industry best practices suggest that any subrogation recovery received be documented and recorded. The subrogation lien was forfeited for one (1) of the two (2) Aviation claims in which third-party liability was identified. The other claim did not have documented evidence of a recovery received.

### **Litigation**

The Claims Management Guide indicates there should be an initial file analysis performed by counsel upon consideration of counsel assignment to a claim. Of the four (4) Aviation claims we tested to which this attribute applied, two (2) claims did not have a documented initial file analysis.

The Claims Management Guide indicates a budget should be developed for potential exposure value and legal expenses. Of the four (4) Aviation claims we tested to which this attribute applied, three (3) did not contain a documented budget for potential exposure value and legal expenses.

The Claims Management Guide states that any legal settlements be authorized by a claims director. Of the three (3) Aviation claims we tested to which this attribute applied, one (1) did not contain documented supervisory authorization of the legal settlement.

### **Closure**

The Claims Management Guide sets out timing standards in terms of the initial claims handling, investigation, and closure. The guide's best practices state within two (2) days of claim assignment, initiation of contacts, action plan/summary, and initial claim set-up should all be documented. The presence of all of these elements occurring for a claim in the guide prescribed timeframe would constitute an "aggressively" handled file. Of the 10 Aviation claims we tested to which this attribute applied, we determined all were handled in accordance with the Claims Management Guide.

The Claims Management Guide sets forth best practice standards for on-going bill monitoring, payment, and monthly tracking. These stipulations should ensure that all bills are paid prior to a claim file being closed; and if bills do arise after a claim is closed, they should be minimal and sparse. Of the 10 Aviation claims we tested that were closed and to which this attribute applied, all were handled in accordance with best practices set forth in the guide.

A timely closure process should occur for all claims as indicated throughout the Claims Management Guide. Of the 13 Aviation claims we tested to which this attribute applied, we determined one (1) was not closed timely. Based on commonly accepted workers' compensation insurance industry best practices, this would generally be within 30 days after the last reasonably expected benefit liability is paid.

### **Miscellaneous**

As stated in the Claims Management Guide, the goal of disability management is to return employees to work in a timely manner. Of the 12 Aviation claims we tested to which this attribute applied, we determined all of the claims had return to work properly documented and addressed.



Per of the Claims Management Guide, the topic of a SIU is addressed. It states the SIU should be considered throughout the claim process, from point of intake all the way through closure. Of the Aviation claims we tested, use of the SIU was not applicable.

A review for Medicare coverage of eligible claimants should be conducted. All 17<sup>17</sup> Aviation claims we tested to which this attribute applied accounted for Medicare eligibility verification.

The Claims Management Guide states as a best practice, thorough and completed diaries are critical to claims management. This attribute applied to 17 of the Aviation claims we tested and of those claims we tested, we determined one (1) claim file did not have an accurate and complete diary.

### **Federally Funded Civilian**

#### **File Administration**

The Program's CSI the City filed with CCMSI indicates all claims and initial claim data should be reviewed by a CCMSI supervisor when a new claim is received to make an initial compensability assessment. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, supervisor review documentation was in all of the claim files.

As previously noted, it is commonly accepted workers' compensation insurance industry best practice to assign a claim to an adjuster within 24 business hours of the claim having been received by the Program; in order to expedite claim processing and ensure timely completion of subsequent steps after claim intake. This testing attribute applied to all five (5) Federally Funded Civilian claims we tested, and all were assigned to an adjuster within 24 hours.

While the Program's Claim's Management Guide does not govern CCMSI's practices, for testing comparability purposes we applied the guide's stipulations against the claims handled by CCMSI that were subject to our testing. As stipulated by the guide, the claimant's AWW and TTD benefit amounts should be calculated within two (2) days of the claim being assigned to a claim adjuster. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, all had AWW/TTD calculated timely.

#### **Initial File Review**

The Program's Claims Management Guide contains best practices to conduct an initial file analysis ("IFA") upon claim assignment. Grant Thornton tested IFA documentation against commonly accepted workers' compensation insurance industry best practices that generally allow 24 to 48 hours after the claim is assigned to an adjuster for such a review. This attribute applied to all five (5) Federally Funded Civilian claims tested. The timely IFA was documented for all five (5) Federally Funded Civilian claims tested.

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<sup>17</sup> Medicare does not apply to *Medical Only* claims as settlements do not take place for medical only claims. As such, there is no requirement to protect Medicare's interest where no settlement has taken place.



The Claims Management Guide contains a best practice to obtain a recorded statement from all claimants. Of the two (2) Federally Funded Civilian claims we tested to which this attribute applied, both had evidence of a recorded statement.

The Claims Management Guide contains a best practice to obtain a witness statement on all Medical Only, Indemnity, and Managed Medical claims. There were no Federally Funded Civilian claims we tested to which this attribute applied.

The Claims Management Guide contains a best practice that an Action Plan/Summary should be documented. Of the five (5) Federally Funded Civilian claims tested to which this attribute applied, all contained a documented Action Plan/Summary and subsequent supervisory reviews.

The Claims Management Guide contains a best practice that compensability determinations be complete and documented within two (2) business days after claim assignment to an adjuster. Of the five (5) Federally Funded Civilian claims to which this attribute applied we tested, all five (5) claims contained a documented compensability determination and it was done so in a timely fashion.

### **Benefit Delivery/Wages**

It is the Program's process that the assigned claims adjuster calculates AWW and TTD, and verifies the calculation against the claimant's wage statement. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, all of them had a documented AWW verification.

Per the Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that Temporary Disability stop letters be sent to the claimant within 14 days of benefits being stopped. Of the two (2) Federally Funded Civilian claims we tested to which this attribute applied, CCMSI did not send Temporary Disability stop letters to either of those claimants.

We identified overpayment for one (1) of the five (5) Federally Funded Civilian claims to which this attribute applied; however, the overpayment was subsequently recovered.

### **Medical Review**

The Program's Claims Management Guide stipulates the claim adjuster should conduct an initial and ongoing review of available medical records, which should be documented and summarized. All five (5) Federally Funded Civilian claims to which this attribute applied contained a documented medical review.

The Program's Claims Management Guide contains a best practice to obtain a signed medical release (Medical Authorization Request) from the employee. All five (5) Federally Funded Civilian claims to which this attribute applied, had evidence of this medical release being retained.

The Program's Claims Management Guide stipulates a medical canvas for additional records should be conducted and documented and summarized. All five (5) of the Federally Funded Civilian claims we tested to which this attribute applied had a medical review properly documented.





The Program's Claims Management Guide references the Act's authorization to employers to conduct a drug and alcohol test on employees after they are involved in any incident that results in a fatality or injury which occurs while on duty or while performing acts on the behalf of the employer. None of the five (5) Federally Funded Civilian claims we tested failed this attribute test.

## **Forms**

The Act requires employers to file FROI reports for all claims resulting in more than three (3) days of lost wages for the employee. Of the two (2) Federally Funded Civilian claims we tested to which this attribute applied, one (1) did not contain evidence in the file that a FROI was manually filed with the Illinois Worker's Compensation Commission as required under Section 6(b) of the Act.

Per the Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that delay letters be sent to the claimant if a compensability decision will not be made within 14 days of being notified or when they are aware of a related liability that will delay compensability determination. This attribute did not apply to the five (5) Federally Funded Civilian Claims we tested.

Per the Illinois Workers' Compensation Commission, Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that denial letters be sent to claimants within 14 days of being notified or when they are aware of a related liability if the employer denies liability for payment of temporary total compensation with a written explanation of the basis for denial. Of the one (1) Federally Funded Civilian claim we tested that was denied, the claim file contained documentation of an adequate denial letter being sent to the claimant.

Reserves for claims managed by CCMSI are documented within the tabs of the claim file. As such, the reserves worksheet testing attribute would not have been applicable to these claims. However, Grant Thornton noted that all Federally Funded Civilian claims tested contained documented reserves within claim files within ICE.

## **Reserves**

It is the Program's best practice that reserves for all applicable claims be set timely, which the Program defines as two (2) business days from claim assignment to an adjuster. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, one (1) did not have reserves set timely.

It is commonly accepted workers' compensation insurance industry best practice to set reserve exposure for potential ultimate probable cost or expected future Indemnity and medical payments. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, all contained adequately calculated exposure reserves.

Grant Thornton noted it is commonly accepted workers' compensation insurance industry best practice that reserves be properly set to pay for future and expected bills associated with a claim, and not on an ad hoc basis or "stair-stepping". According to commonly accepted workers' compensation insurance industry best practices, reserves should be set within two (2) business days. All Federally Funded Civilian claims we





tested had reserves adequately set at the onset of a claim and we did not identify a practice of “stair-stepping”.

### **Subrogation**

The Program Claims Management Guide contains a best practice that potential third-party liability be assessed for all applicable claims. This attribute applied to all five (5) Federally Funded Civilian claims we tested and all addressed subrogation in the claim file.

Commonly accepted workers’ compensation insurance industry best practices suggest all claims should be assessed for potential third-party liability, and if applicable, perform a liability analysis. This attribute did not apply to any of the Federally Funded Civilian claims we tested.

Commonly accepted workers’ compensation insurance industry best practices suggest that any subrogation recovery received be documented and recorded. This attribute applied to one (1) of the Federally Funded Civilian claims we tested and the claim file contained documented evidence that recovery receipt was pending at the time of testing.

### **Litigation**

The Claims Management Guide states there should be an initial file analysis performed by counsel upon consideration of counsel assignment to a claim. This attribute did not apply to any of the Federally Funded Civilian claims we tested.

The Claims Management Guide states a budget should be developed for potential exposure value and legal expenses. This attribute did not apply to any of the Federally Funded Civilian claims we tested.

The Claims Management Guide states that a claims director should authorize any legal settlements. This attribute did not apply to any of the Federally Funded Civilian claims we tested.

### **Closure**

The Claims Management Guide sets out timing standards in terms of the initial claims handling, investigation, and closure. The guide states within two (2) days of claim assignment, initiation of contacts, action plan/summary, and initial claim set-up should all be documented. The presence of all of these elements occurring for a claim in the guide prescribed timeframe would constitute an “aggressively” handled file. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, we determined all were handled in accordance with the Claims Management Guide.

The Claims Management Guide sets forth best practice standards for on-going bill monitoring, payment, and monthly tracking. These stipulations should ensure that all bills are paid prior to a claim file being closed; and if bills do arise after a claim is closed, they should be minimal and sparse. Of the five (5) Federally Funded claims we tested that were closed and to which this attribute applied, all were handled in accordance with best practices set forth in the guide.

A timely closure process should occur for all claims as indicated throughout the Claims Management Guide. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, all were handled in accordance with best practices set forth in the guide.



## Miscellaneous

As mentioned in the Claims Management Guide, the goal of disability management is to return employees to work in a timely manner. Of the five (5) Federally Funded Civilian claims we tested to which this attribute applied, we determined all of them had return to work properly documented and addressed.

Per the Claims Management Guide, the topic of a SIU is addressed. It states the SIU should be considered throughout the claim process, from point of intake all the way through closure. None of five (5) Federally Funded Civilian claims we tested had SIU involvement.

It is commonly accepted workers' compensation insurance industry best practice a review for Medicare coverage of eligible claimants should be conducted. All five (5)<sup>18</sup> Federally Funded Civilian claims we tested to which this attribute applied accounted for Medicare eligibility verification.

The Claims Management Guide states as a best practice, thorough and completed diaries are critical to claims management. For the five (5) Federally Funded Civilian claims we tested, we determined each of them had an accurate and complete diary.

## d. Recommendations

### File Administration

**Supervisor/Director Review:** Written policies and procedures should be developed, clarifying Program management's roles within the claims administration process from claim intake to closure. Records should be kept and a queue created detailing new claims received, claims reviewed, and claims still pending. Commonly accepted workers' compensation insurance industry best practices indicate this should be done daily. Program management review could be implemented to ensure accountability. All activity should be noted within the claim file review notes or Notepad.

**File Assigned within 24 Hours:** Claim file assignment to an adjuster should be based on daily incoming case load and staffing levels, with exceptions made for extraordinary cases or circumstances. Commonly accepted workers' compensation insurance industry best practices indicate claim file assignment should occur within 24 hours. A monitoring mechanism should be established to ensure adherence to timely assignment of claims.

**AWW/TD:** The Program should consider adding a review process on the 3<sup>rd</sup> business day from date of claim receipt to ensure that AWW and TD rates are calculated and processed timely. Any exceptions should be reviewed, recorded, and tracked for progress or lack thereof. All activity should be noted within the claim file review notes or Notepad.

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<sup>18</sup> Medicare does not apply to Medical Only claims as settlements do not take place for medical only claims. As such, there is no requirement to protect Medicare's interest where no settlement has taken place.



## Initial File Review

**Initial File Analysis within 24/48 hrs.** Written policies and procedures should be developed, clarifying Program management's roles and review requirements within the claims administration process and IFA. Commonly accepted workers' compensation insurance industry best practices indicate this should be done within 24-48 after claim file assignment. Program management review should be implemented to ensure accountability and verification analysis is being performed. All activity should be noted within the claim file review notes or Notepad.

**Recorded Statement:** Program management should establish a documented and robust process surrounding review of the Notepad Activity Report. Any new losses that have zero activity within the Notepad or no documented attempts of contact within the designated timeline (defined in the Claims Management Guide as no later than the end of the next business day following the first business day reported) should be prompt notification to the claim adjuster and requirement to provide status and follow-up. The Program should consider setting follow up diary tasks on an automatic basis which notify Program management if claimant contact is not completed within best practice requirements.

**Witness Statement:** Witness statement forms could be provided to each City department's Human Resources team for the witness to complete immediately following the injury and the statement could be submitted with the initial notice of injury.

**Action Plan/Summary Provided:** Written policies and procedures should be developed detailing roles and responsibilities of claim adjusters and Program management for completing and reviewing the Action Plan/Summary. Lack of an Action Plan/Summary in combination with an adjuster's case load could hinder the ability of the adjuster to efficiently and effectively move through the claims administration process to the detriment of the claimant and the claimant's department as a whole. Program leadership review/oversight should be considered for accountability purposes.

**Compensability Determination Performed:** Written policies and procedures should be developed detailing roles and responsibilities of claim adjusters and Program management for compensability determination. Commonly accepted workers' compensation insurance industry best practices suggest a supervisory report review be performed mid-month for a prior month's claims. More frequent iterations of the report review should be considered until initial claims handling metrics are brought to appropriate levels. Program leadership review/oversight should be considered to ensure determination is being performed. All activity should be noted within the claim file review notes or Notepad.

## Benefit Delivery/Wages

**Stop TD Letters (State Regulation Section 9110.70):** Title 50, Chapter 6, Part 9110, Section 9110.70 of the Joint Committee on Administrative Rules Administrative Code requires that Temporary Disability stop letters be sent to the claimant within 14 days of benefits being stopped. Written policies and procedures should be developed and implemented to ensure the Program is Temporary Disability stop letters in compliance with applicable laws and regulations.

**Overpayment on File:** All overpayments we identified were related to Indemnity benefits paid after Indemnity benefits were stopped or because of an incorrect calculation of Indemnity benefits. Periodic supervisory review should be established to ensure claims payments are accurately made and to



mitigate the risk of overpayment. Attempt at recovery of overpayments should be made during the course of the claim or at the time of claim settlement in an effort to recover any overpayment made. All activity should be noted within the claim file review notes or Notepad.

## **Medical Review**

**Medical Analysis Completed:** Written policies and procedures should be developed to require Program management's review of claim adjusters conducting initial review and on-going analysis. This could be accomplished by reviewing the Medical Notepad within iVOS as well as medical reports and bills housed within Coventry Connect. All activity should be noted within the claim file review notes or Notepad.

**Medical Authorization Request Sent:** Written policies and procedures should be developed to require Program management review to ensure claim adjusters obtain medical release forms, properly document them in the Medical Notepad, and summarize them in the Action Plan/Summary Notepad.

**Medical Canvas Performed:** Written policies and procedures should be developed to require Program management's review to ensure claim adjusters obtain medical release forms, properly document them in the Medical Notepad, summarize them in the Action Plan/Summary Notepad, and complete ISO indexing.

**Drug Test Performed:** Written policies and procedures should be developed to require Program management periodically review "Examination Tracking" reports within iVOS to verify claim adjusters administer drug and alcohol tests and document results for applicable claims.

## **Forms**

**FROI Report Filed:** Written policies and procedures should be developed and implemented to ensure the Program complies with the Act's requirement to file FROI reports for claims resulting in more than three (3) days of lost wages for the employee. The Program advised Grant Thornton it will be ready for electronic reporting of the FROI, as required by the Act effective June 2019. Failure to file electronic FROI reports will cause the Program to be noncompliant with the Act.

**Delay Letter Sent – Within 14 Days (State Regulation Section 9110.70):** Written policies and procedures should be developed and implemented to ensure delay letters are sent to the claimant if a compensability decision will not be made within 14 days of being notified or when they are aware of a related liability that will delay compensability determination.

**Denial Letter Sent - Within 14 Days (State Regulation Section 9110.70):** Written policies and procedures should be developed and implemented to ensure the Program issues TTD payments within 14 days of claim notification, if due. Otherwise, a denial letter should be sent to the claimant within 14 days of claim notification, if the employer denies liability for payment of temporary total compensation. A written explanation of the basis for denial should be sent and should contain more detail than the language currently being used.

**Settlement/Reserve Analysis:** A claim settlement analysis should be completed on any claim that is litigated or where permanent partial disability is due. This analysis should be completed in a timely





manner (within 30 days of demand or MMI). Authority provided to assigned legal counsel should be followed up on in 30 day intervals in an effort to move the file to conclusion in a timely manner.

A reserve analysis should be completed on each claim. The reserve analysis should be noted within the Notepad section of iVOS and should present a clear understanding of lost time, potential permanent disability, current medical treatment underway, and the potential of future medical treatment related to the injury. The reserve analysis should also account for expenses related to surveillance, litigation, etc.

## **Reserves**

**Reserves Set Timely/Reserve Exposure:** Program management should develop and implement a process to ensure claim reserves are appropriately set and maintained throughout a claim's lifecycle, and not simply adjusted when bills and expenses come due (i.e., stair-stepping). The Program should train all claims adjusters on how to set reserves for potential exposure. The training should also teach claims adjusters on how to set reserves at ultimate probable cost to minimize the risk of under-reserving, which can ultimately cause significant financial burdens to the Program and City.

## **Subrogation**

**Third-Party Potential Liability Assessed:** The Claims Management Guide provides guidance for subrogation handling, but does not include a review process to ensure subrogation was being assessed. Written policies and procedures should be developed in order to ensure that subrogation potential is either maximized or ruled out.

**Liability Analysis Provided:** If subrogation potential is identified, an analysis should be performed to determine special considerations and the possibility of involvement of subrogation legal counsel to maximize recovery. This should be part of the initial claims handling and investigation notes, which should be documented in the Notepad and the subrogation box in iVOS should be checked within the claims file to confirm the claims adjuster has considered subrogation. Program management should develop a process for reviewing claims to determine subrogation is effectively reviewed and pursued or ruled out.

**Recovery Received:** All claims require review for potential subrogation. Once subrogation is identified, the claim adjuster should either send a lien letter or assign the claim to subrogation legal counsel in an effort to maximize recovery. These claim files should be monitored on an ongoing basis until recovery is received.

## **Litigation**

**Initial File Analysis / Litigation Summary:** Program management should develop a process to validate an initial file analysis and litigation summary are prepared for claims upon assignment to defense legal counsel. Updates should be obtained on an ongoing basis until the claim is brought to final resolution.

**Budget:** If a claim is litigated, defense legal counsel should prepare a budget which is reviewed by the claim adjuster. The adjuster and defense legal counsel should monitor the budget throughout the litigation process to ensure it is being adhered to and defense legal counsel does not exceed the approved





budget without written approval from the Program. Defense legal counsel should present the Program with an updated budget and detailed explanation for the requested increase in writing when seeking the Program's approval. Written policies and procedures should be developed outlining the process for developing the budget, the necessary details when defense legal counsel seeks a budget increase, and how the Program's decision should be documented and maintained. .

**Settlement Authorization Requests:** Defense legal counsel should provide a claim settlement analysis on their assigned claim file, at the appropriate time (i.e., MMI, or upon demand from the plaintiff attorney). Program management should review any claim settlement analysis from defense legal counsel within 30 business days and provide settlement approval based upon their review and knowledge of the file in conjunction with their review of defense legal counsel's analysis. Written policies and procedures should be developed to ensure timely review of all claim settlement requests from defense legal counsel, at all levels, to mitigate FWA risks.

The Program should reassess the parameters and all informal procedures currently in place that may be adversely impacting DOL Torts Division attorneys' autonomy leading to waste and abuse. The Program and the DOL Torts Division attorneys should ensure any parameters in place are sensible and regularly reviewed for propriety.

## Closure

**File Aggressively Handled:** All claim files should be handled in an aggressive manner to ensure timely movement to closure. This is inclusive of Indemnity benefits, medical expenses, and other expenses (e.g., surveillance). Program management should review claims regularly (e.g., on a quarterly basis) to ensure they move forward in a timely and effective manner.

**All Bills Paid:** Written policies and procedures should be implemented to ensure bills are paid prior to claim file closure. Most, if not all, bills should be paid while the claim is still open. The claim adjuster should track bill receipt and contact any providers where bills remain outstanding at the time the claim file is ready for closure.

**Closed Timely:** Productivity requirements should be considered wherein there is a 1:1 closing ratio (a commonly accepted workers' compensation insurance industry standard). Claim files that remain open beyond treatment timeframes or MMI may have reserves outstanding that can adversely affect the City financial statements. Program management review should be implemented to ensure claims move toward closure and handled properly.

## Miscellaneous

**Return to Work ("RTW") Addressed:** To effectively manage disability and workers' compensation, the Program needs to have consistent monitoring and supervisory review surrounding its RTW policies. Work Status tab, Notepad tab, and Claimant contact Notepad within iVOS should all be regularly reviewed. Program management should discuss with claims adjusters why early RTW is important as well as the cost savings that can be associated with it.

**Surveillance Assigned:** Written policies and procedures should be developed and implemented to ensure the SIU is being considered throughout a claim's lifecycle and utilized when appropriate. An RFP process should be developed for any third-party investigative services to ensure prospective third-



parties are cost-effective, can provide quality product, and service expectations are clearly documented. When appropriate, the Program should also consider collaborating with the OIG for further investigative support.

**Diaries:** Written policies and procedures should be developed and implemented for Program management to review diaries within claims files to ensure accurate, completed claims handling occurs for all claims, by all claims adjusters.

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## VIII. PEER JURISDICTION ANALYSIS

### a. Workstream Summary

Grant Thornton was tasked with collecting, aggregating, and analyzing workers' compensation program data from requested peer jurisdictions and comparing that data to the City's Program data to determine if insights could be gleaned to develop strategies for increasing the Program's operational effectiveness and efficiency.

### b. Procedures Performed

Grant Thornton collected and aggregated information and data from select peer jurisdictions. As some jurisdictions were unresponsive to requests or would not provide information requested, Counsel submitted formal Freedom of Information Act ("FOIA") requests. Data was requested from several "sister" City agencies and large metro jurisdictions throughout the United States. See **Table 2** below for a list of jurisdictions and the status of our data requests as of the date of this report. Grant Thornton analyzed the data received for a combination of performance statistics for fiscal years 2014 through 2018, including:

- Total dollar amount of claims paid
- Total number of claims
- Average claim amount
- Percentage of claims approved / denied
- Number of employees on workforce
- Percentage of workforce making / being awarded a claim
- Total administrative costs
- Total administrative costs as a percentage of claims paid
- Average cost to process / manage claims (administrative unit cost)



Agency/Jurisdiction	Status
City of Chicago (Civilian, Police & Fire)	Data received
Chicago Public Schools	Data received
Chicago Parks District	Data received
Chicago Transit Authority	Data received
Denver	Data received
Sacramento	Data received
Seattle	Data received
San Francisco	Partial data received
Dallas	FOIA requested
Los Angeles	FOIA requested
New York City	FOIA requested
Philadelphia	FOIA requested
Atlanta	City unresponsive
Boston	City unresponsive
Houston	City unresponsive
Miami	City unresponsive
San Antonio	City unresponsive
Phoenix	Contact made - Request for information submitted
San Diego	Contact made - Request for information submitted

**Table 2: Peer Agencies and Jurisdictions**





### **c. Findings**

Grant Thornton was unable to determine or confirm from the large metro jurisdictions whether their respective programs included all city workers or if separate programs administered claims for different departments (e.g., police, fire, aviation, or civilian).

As a result of a multitude of factors, findings and observations about peer data comparison could be readily subject to challenge and inconsistent interpretation. Such factors may include, but would not be limited to: varying population sizes, geographies<sup>19</sup>, municipal services provided via employees covered by local jurisdictional workers' compensation benefit plans, and governing laws and regulations applicable to each jurisdiction.

A peer benchmarking exercise involving jurisdictions outside the State of Illinois would likely not provide the City with an equivalent baseline for comparison due to differing State laws, statutes, or rules governing workers' compensation benefits. Furthermore, a comparison between the City's Program and workers' compensation benefits programs administered by "sister" agencies presents difficulty when trying to draw comparisons due to varying employee workforce sizes and work performed by those employees.

### **d. Recommendations**

The City or the Program should establish its own formal peer jurisdiction analytic program to be performed on a periodic basis (e.g., bi-annual) to allow the City to have a better opportunity to proactively identify unusual patterns or trends that might be indicative of FWA that other jurisdictions are not experiencing or have put more robust controls in place to prevent and detect potential FWA. We also recommend the City form a core group of fiscal leadership with responsibilities related to administering and accounting for the City's Program that can periodically connect with and network with peers in other jurisdictions to learn what other jurisdictions are finding to be best practices to prevent and detect FWA. The Program should consider performing a three (3) to five (5) year rolling analysis of the Program's financial performance with consideration of the above mentioned performance statistics.

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<sup>19</sup> Geographies includes consideration for general weather patterns in each metro jurisdiction. For example, jurisdictions in the State of California may encounter less severe weather (i.e., snow and ice) compared to jurisdictions like Boston, the City, and New York City.



While this is not an exhaustive list, Grant Thornton identified several general best practices commonly found in municipal workers' compensation programs that the City of Chicago could benefit from and should consider implementing listed below:

- Establishing specific reporting periods (i.e., FROI report). For example, 'Injury must be reported to employer within 21 days of employee injury. After 120 days the injury is non-compensable.'  
NOTE: Any such City guidelines should be drafted in conformity with governing State of Illinois, federal, and local laws and regulations.
- Establishing consistent review processes throughout the entire lifespan of the claim.
- Actively monitoring the employee recovery period and maintaining contact with the employee.
- Developing a robust and mandated participation and use of a return to work program.  
Maintaining reasonable reserves for anticipated future medical costs.



**CITY OF CHICAGO  
WORKERS' COMPENSATION PROGRAM**

**GRANT THORNTON LLP  
FINAL REPORT - APPENDICES  
MAY 10, 2019**



IX. APPENDICES

a. Appendix A – City of Chicago Workers Comp. Program: Fraud Risk Map

Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Asset Misappropriation	Claimant Fraud	Falsified Injury or Illness	City Employee	Injury on Duty Report	A worker fabricates an injury or illness to obtain workers' compensation benefits.	<p>An employee might invent injuries or illnesses they don't have to get time off and financial benefits from the workers compensation program.</p> <p>Example: An employee makes up hearing loss to receive workers' compensation benefits.</p> <p>City: The Program has access to several tools to prevent an employee from receiving benefits for too long. Such tools include: witness and supervisor statements, investigative tools and surveillance, Independent Medical Exams ("IMEs"), and nurse case managers.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Asset Misappropriation	Claimant Fraud	Exaggerated Injury or Illness	City Employee	Injury on Duty Report	A worker exaggerates an injury or illness to increase their workers' compensation benefits and/or prolong them.	<p>A City employee might exaggerate their illnesses or injuries. The employee might be suffering from a minor injury or illness, but it does not prevent them from working.</p> <p>Example: The employee has a sore shoulder from a minor on-the-job injury. The employee inflates his injury and pretends that he cannot use his arm so he can stay home and receive benefits.</p> <p>City: The Program has access to several tools to prevent an employee from receiving benefits for too long. Such tools include: witness and supervisor statements, investigative tools and surveillance, IMEs, and nurse case managers.</p>
External	Asset Misappropriation	Claimant Fraud	Non Work-related Injury or Illness	City Employee	Injury on Duty Report	A worker claims an injury or illness is work-related when it is in fact not work related in order to obtain workers' compensation benefits.	<p>An employee can commit workers' compensation fraud by pretending they got injured on the job when their injury came from elsewhere. Or, the employee might have an old injury that resurfaces, and they say they got it while at work.</p> <p>Example: An employee has a skiing injury that injures his back. He pretends to slip on a wet floor to receive workers' compensation benefits.</p>





Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Collusion	Claimant Fraud	Falsified Injury or Illness	City Employee, Medical Provider	Injury on Duty Report, Medical Bills	A worker in collusion with a medical provider falsifies an injury or illness in order to obtain workers' compensation benefits.	City: While the Program has successfully identified cases of medical providers that over-treat; there is no mechanism to systematically prevent and detect cases of collusion between claimants and medical providers.
External	Collusion	Claimant Fraud	Exaggerated Injury or Illness	City Employee, Medical Provider	Injury on Duty Report, Medical Bills	A worker in collusion with a medical provider exaggerates an injury or illness to increase their workers' compensation benefits and/or prolong them.	City: While the Program has successfully identified cases of medical providers that over-treat; there is no mechanism to systematically prevent and detect cases of collusion between claimants and medical providers.
External	Collusion	Claimant Fraud	Non work-related Injury or Illness	City Employee, Medical Provider	Injury on Duty Report, Medical Bills	A worker in collusion with a medical provider claims an injury or illness is work-related when it is in fact not work related in order to obtain workers' compensation benefits.	City: While the Program has successfully identified cases of medical providers that over-treat; there is no mechanism to systematically prevent and detect cases of collusion between claimants and medical providers.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Asset Misappropriation	Claimant Fraud	Secondary Employment	City Employee, Police and Fire	Approved prior employment	A worker gains secondary employment either part-time or full-time to receive compensation without reporting it so that they may continue to receive workers' compensation benefits.	City: The CBAs for both Police and Fire departments allow sworn officers to maintain secondary employment. While secondary employment must be pre-approved by the respective departments, there is no documented mechanism by which the departments can prohibit or monitor secondary employment while the claimant is receiving benefits.
External	Asset Misappropriation	Medical Provider Fraud	Fictitious Services	Medical Provider	Injury on Duty Report, Medical Bills	A medical provider bills for services not rendered related to a workers' compensation claim.	City: Adjusters review medical bills for purposes of completing iVOS diaries and to perform overall oversight of claims. Coventry also reviews medical bills, provides estimated ranges of total medical bills for a given injury type, and provides case management nurses to oversee care upon request. However, in order for these mechanisms to operate effectively, claims injuries must be documented in detail.
External	Asset Misappropriation	Medical Provider Fraud	Unnecessary Services	Medical Provider	Injury on Duty Report, Medical Bills	A medical provider bills for unnecessary services related to a workers' compensation claim.	City: The Program has IMEs and nurse case management at its disposal to identify when medical services and procedures may be unnecessary. However, there appears to be no systematic mechanism to monitor propriety of services rendered by medical providers.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Asset Misappropriation	Medical Provider Fraud	Double-Billing	Medical Provider	Medical Bills	A medical provider double-bills for services rendered related to a workers' compensation claim.	City: Adjusters use the medical visit dates to manage iVOS diaries to help monitor upcoming medical visits. Coventry reviews medical bills but only for adjustment to the Illinois fee schedule. There is no systematic, documented mechanism by which the program might be able to prevent and detect duplicate billing. Further, there is no mechanism to prevent bills being paid on closed claims, which might increase the risk of the program processing duplicate bills.
External	Collusion	Medical Provider Fraud	Fictitious Services	City Employee, Medical Provider	Medical Bills	A medical provider in collusion with a worker bills for services not rendered related to a workers' compensation claim.	City: There are no controls in place to prevent a medical provider from fabricating services to over bill the program. The only way this would be identified is through investigation of the medical provider's notes and interviews with the provider's staff.
External	Collusion	Medical Provider Fraud	Unnecessary Services	City Employee, Medical Provider	Medical Bills	A medical provider in collusion with a worker bills for unnecessary services related to a workers' compensation claim.	City: The program has IMEs and nurse case management at its disposal to identify when medical services and procedures may be unnecessary. However, there appears to be no systematic mechanism to monitor propriety of services rendered by medical providers.
External	Collusion	Medical Provider Fraud	Double-Billing	City Employee, Medical Provider	Medical Bills	A medical provider in collusion with a worker submits duplicate bills for services rendered related to a workers' compensation claim.	City: Adjusters use the medical visit dates to manage iVOS diaries to help monitor upcoming medical visits. Coventry reviews medical bills but only for adjustment to the Illinois fee schedule. There is no systematic, documented mechanism by which the program might be able to prevent and detect duplicate billing. Further, there is no mechanism to prevent bills being paid on closed claims, which might increase the risk of the Program processing duplicate bills.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Collusion	Bribery	Falsified Injury or Illness	Program Employee, City Employee	Compensability Determination, Medical Bills	A Program employee accepts a bribe, or kickback, from an external party to approve and/or pay a fictitious workers' compensation claim.	External parties may include City employees or medical providers.  City: Due to the volume of claims, workload on Program management, and inherent difficulty in catching collusion schemes, this scheme would be extremely difficult to identify.
Internal	Collusion	Bribery	General Program Fraud	Program Employee, City Employee	Multiple	A Program employee accepts a bribe from another internal party in order to assist in or hide fraudulent activity.	City: Due to the volume of claims, workload on program management, and inherent difficulty in catching collusion schemes, this scheme would be extremely difficult to identify.
Internal	Collusion	Bribery	Inappropriate Access to Program Assets	Program Employee, City Employee	Program Offices	A Program employee accepts a bribe in order to provide inappropriate physical premises access to unauthorized individuals.	City: Access to the program offices are controlled by key-card. Access to premises should be reviewed periodically to identify access anomalies.
Internal	Collusion	Bribery	Inappropriate Access to Program Assets	Program Employee, City Employee	System credential creation	A Program employee accepts a bribe in order to provide inappropriate system access to unauthorized individuals.	City: Currently, access to the system is controlled by the IT department, with access being directed by a documented business need. Management should periodically monitor access, roles, and access levels to the system.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Collusion	Bribery	Exaggerated Injury or Illness	Program Employee, City Employee	Medical Bills	A Program employee accepts a bribe, or kickback, from an external party to approve and/or pay an exaggerated workers' compensation claim.	External parties may include City employees or medical providers.  City: Due to the volume of claims, workload on program management, and inherent difficulty in catching collusion schemes, this scheme would be extremely difficult to identify.
Internal	Collusion	Bribery	Non work-related Injury or Illness	Program Employee, City Employee	Compensability Determination	A Program employee accepts a bribe, or kickback, from an external party to approve and/or pay a non-work-related workers' compensation claim.	External parties may include City employees or medical providers.  City: Due to the volume of claims, workload on program management, and inherent difficulty in catching collusion schemes, this scheme would be extremely difficult to identify.
Internal	Collusion	Conflict of Interest	Falsified Injury or Illness	Program Employee	Injury on Duty Report, Voucher Creation	A Program employee approves and/or pays a fictitious workers' compensation claim in which they have an undisclosed conflict of interest.	City: Several people within the Program anecdotally disclosed their self-recusal from claims in which they were perceived to have a conflict of interest with the claimant. However there was no documented policy that required, or mechanism by which, Program personnel could recuse themselves from claims in which there was a conflict of interest, real or perceived.





Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Collusion	Conflict of Interest	Exaggerated Injury or Illness	Program Employee	Injury on Duty Report, Voucher Creation	A Program employee approves and/or pays an exaggerated workers' compensation claim in which they have an undisclosed conflict of interest.	City: Several people within the Program anecdotally disclosed their self-recusal from claims in which they were perceived to have a conflict of interest with the claimant. However, there was no documented policy that required, or mechanism by which, Program personnel could recuse themselves from claims in which there was a conflict of interest, real or perceived.
Internal	Collusion	Conflict of Interest	Non work-related Injury or Illness	Program Employee	Injury on Duty Report, Voucher Creation	A Program employee approves and/or pays a non-work-related workers' compensation claim in which they have an undisclosed conflict of interest.	City: Several people within the Program anecdotally disclosed their self-recusal from claims in which they were perceived to have a conflict of interest with the claimant. However, there was no documented policy that required, or mechanism by which, Program personnel could recuse themselves from claims in which there was a conflict of interest, real or perceived.
Internal	Collusion	Conflict of Interest	N/A	Program Employee, City Employee	Injury on Duty, Voucher Creation, Medical Bills	A Program employee attempts to influence the approval and/or payment of a workers' compensation claim - on behalf of external parties in which the internal party has a hidden conflict of interest.	External parties may include workers, medical providers, lawyers, etc.  City: Several people within the Program anecdotally disclosed their self-recusal from claims in which they were perceived to have a conflict of interest with the claimant. However, there was no documented policy that required, or mechanism by which, Program personnel could recuse themselves from claims in which there was a conflict of interest, real or perceived.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Collusion	Economic Extortion	N/A	Program Employee, City Employee	Compensability Determination	A Program employee demands personal payment from an external party as stipulation for approval and/or payment of a workers' compensation claim.	External parties may include workers, medical providers, lawyers, etc.  City: Compensability is reviewed by both the Program director and Claims Counsel. As long as there is some sort of review and monitoring of compensability and claim management, this risk might be adequately mitigated.
Internal	Collusion	Economic Extortion	N/A	Program Employee	Multiple	A Program employee demands personal payment from another internal party as stipulation for not reporting inappropriate activity.	City: Due to the volume of claims, workload on Program management, and inherent difficulty in catching collusion schemes, this scheme would be extremely difficult to identify.
Internal	Collusion	Illegal Gratuities	N/A	Program Employee, City Employee	Medical Bills	A Program employee accepts a personal benefit or something of value from an external party after the Program employee approves and/or pays a workers' compensation claim.	External parties may include workers, medical providers, lawyers, etc.  City: Due to the volume of claims, workload on Program management, and inherent difficulty in catching collusion schemes, this scheme would be extremely difficult to identify.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Collusion	Illegal Gratuities	N/A	Program Employee	Medical Bills	A Program employee accepts a personal benefit from another Program employee as reward for completion of an activity that violates policy.	<p>For example, the internal party may have made a false statement related to the other party's performance to their benefit. Based on this action, the party then provided a personal benefit, such as money, to the other party as a reward for providing the false statement after the fact.</p> <p>City: Periodic and ongoing communication of the City's ethics policies and hotlines should be distributed to aid in mitigating this risk.</p>
Internal	Asset Misappropriation	Expense Reimbursement Schemes	Mischaracterized Expenses	Program Employee	Expense Reimbursement	A Program employee requests reimbursement for a personal expense by claiming that the expense is business related.	<p>Businesses typically reimburse their employees for out-of-pocket expenses that their policies identify as reimbursable, such as, travel, lodging and meals. In a mischaracterized expense reimbursement scheme, the perpetrator simply requests reimbursement for an expense that is not actually business-related.</p> <p>For example, an employee takes his family on a vacation and requests reimbursement for his hotel stay. He submits the receipt and falsifies his expense report to indicate that the costs incurred were for business purposes. The false report prompts the organization to issue a check, reimbursing the employee for his or her personal expenses which becomes a free vacation for the employee and his or her family.</p> <p>A common element of mischaracterized expense schemes is a failure to submit detailed expense reports, or any expense reports at all. Some companies provide employees with company credit cards and allow employees to spend company funds without providing detailed information justifying the purchase.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Expense Reimbursement Schemes	Overstated Expenses	Program Employee	Expense Reimbursement	A Program employee inflates the cost of actual business expenses on their expense reimbursement to increase their payout.	In an overstated expense reimbursement scheme, the employee inflates the cost of actual business expenses. This can be perpetrated in a variety of ways, including modifying receipts or over-purchasing and benefiting from a refund or discount. In many cases, this scheme may not be carried out by the employee but by the colleague who handles or processes expense reports. For example, an administrative assistant who processes expense reports may alter the expense report of his or her co-worker and insert a larger dollar amount for reimbursement. He or she then passes on the reimbursement to the colleague for the amount requested and walks away with the remaining amount.
Internal	Asset Misappropriation	Expense Reimbursement Schemes	Fictitious Expenses	Program Employee	Expense Reimbursement	A Program employee submits a request for reimbursement for wholly fictitious expenses, as opposed to overstating real business expenses or seeking to be reimbursed for personal expenses.	<p>In a fictitious expense reimbursement scheme, an employee submits a request for reimbursement for wholly fictitious expenses. The individual develops a false expense report and submits it for reimbursement, as opposed to overstating real business expenses or seeking to be reimbursed for personal expenses.</p> <p>An internal party may create fraudulent supporting documents, such as false receipts. Not all companies require receipts to be attached to expense reports. Another way perpetrators use actual receipts to generate unwarranted reimbursements is by submitting expense reports for expenses that were paid by others.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Expense Reimbursement Schemes	Multiple Reimbursements	Program Employee	Expense Reimbursement	A Program employee submits a request for reimbursement for the same expense multiple times.	In the case of a multiple reimbursement scheme, the perpetrator submits a request for reimbursement for the same expense multiple times. Most often, the fraudster will submit several forms of documentation as support for the same expense. For example, an employee purchases a train ticket for business travel and submits the receipt generated at the ticket counter to the supervisor for reimbursement. A month or so later, he or she submits a second form of proof of payment such as an email confirmation of the reservation or a credit card statement to a different supervisor so that neither would see both expense reports. The organization ends up reimbursing the perpetrator for the travel expense twice.





Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Payroll	Falsified Wages	Program Employee	City FMPS	A Program employee submits an unauthorized pay rate increase, either for themselves or another program employee/accomplice.	<p>The most common method of misappropriating funds from the payroll is the overpayment of wages. For hourly employees, the size of the paycheck is based on two factors: the number of hours worked and the rate of pay. Therefore, for hourly employees to fraudulently increase the size of their paycheck, they must either falsify the number of hours they have worked or change their wage rate. Because salaried employees do not receive compensation based on their time at work, in most cases, these employees generate fraudulent wages by increasing their rate of pay.</p> <p>An employee's personnel or payroll records reflect their rate of pay. If an employee can gain access to these records or has an accomplice with access to them, they can adjust the rate so that they receive a larger paycheck. Employees may collude with the payroll clerk to perpetrate this scheme. A cleverer clerk will then return the pay rate to its original level after committing this fraud for just a few pay periods, so that the issue is less easy to spot. This can be detected by matching pay rate authorization documents to the payroll register.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Payroll	Unauthorized Hours	Program Employee	City FMPS	A Program employee pads their time sheet or the time sheet of an accomplice, such as recording nine hours when they only worked eight, to increase their pay.	The most common method of misappropriating funds from the payroll is the overpayment of wages. For hourly employees, the size of the paycheck is based on two factors: the number of hours worked and the rate of pay. Therefore, for hourly employees to fraudulently increase the size of their paycheck, they must either falsify the number of hours they have worked or change their wage rate. Because salaried employees do not receive compensation based on their time at work, in most cases, these employees generate fraudulent wages by increasing their rate of pay. Perhaps the most common type of payroll fraud is the padding of time sheets by employees, usually in small enough increments to escape the notice of supervisors. This is a particular problem when supervisors are known to make only cursory reviews of time sheets. The best control over this type of fraud is the supervisory review.
Internal	Asset Misappropriation	Payroll	N/A	Program Employee	City FMPS	A Program employee intentionally fails to record personal time off, or underreports the time taken off.	By underreporting personal time off, an employee may end up using more personal time off than is allocated to him/her and depriving the City of his/her time spent working on City activities.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Payroll	Ghost Employee	Program Employee	City FMPS	A Program employee creates a fake employee in the payroll records and falsifies the payment record so that the direct deposit information is replaced with bank account information of his/her own.	Illicit funds can be generated by funneling phony salary payments to fictitious or former employees (i.e., ghost employees), or by making extra payments to presently salaried employees who then either return them to the payer or pass them on to the recipient. A ghost employee is someone who is on the payroll register but who does not actually work for the company. Through the falsification of personnel or payroll records, a fraudster causes paychecks to be generated to a non-employee, or a ghost. The fraudster or an accomplice then converts these paychecks for their own benefit. The ghost employee may be a fictitious person or a real individual who simply does not work for the victim employer. When the ghost is a real person, it is often the perpetrator's friend or relative. For a ghost employee scheme to work, four things must happen: (1) the ghost must be added to the payroll, (2) timekeeping (for an hourly employee) and wage rate information must be collected, (3) a paycheck must be issued to the ghost, and (4) the check must be delivered to the perpetrator or an accomplice. Individuals with authority to add new employees and remove terminated employees are in the best position to put ghosts into the payroll.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Payroll	Ghost Employee	Program Employee	City FMPS	A Program employee prolongs the pay of an employee who has just left the City, and alters the payment record so that the direct deposit information is replaced with bank account information of his/her own.	The payroll staff either creates a fake employee in the payroll records or prolongs the pay of an employee who has just left the company, and alters the payment record so that the direct deposit payment or paycheck is made out to them. This works best in large companies where supervisors have very large staffs and so do not usually track compensation in sufficient detail. It also works well when an employee has left the company and has not yet been replaced, so a fraudster can create a ghost employee until a new employee is hired. Periodic auditing of the payroll records is needed to spot ghost employees. Another way to spot a ghost employee is when there are no deductions from a paycheck, since the perpetrator wants to receive the maximum amount of cash.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Check Tampering	Theft	Program Employee	Voucher Creation	A Program employee intercepts a disbursement and alters the payee designation so that the program employee or an accomplice can convert the check for their personal benefit.	<p>Check tampering is unique among the fraudulent disbursement schemes because it is the one group in which the perpetrator physically prepares the fraudulent check. In these schemes, the perpetrator takes physical control of a check and makes it payable to himself through one of several methods.</p> <p>In this scheme, an internal party may alter the payee designation on a check by inserting the false payee's name in place of the true payee's (the true name might be scratched out or covered up) or by entering into the accounts payable system and changing the payees' names before checks are generated.</p> <p>Checks can also be altered by changing the name of the real payee designation, changing the amount the check is issued for, or leaving the payee designation blank.</p> <p>City: While all payees must be established via 1099 and or listing FMPS, the City's HR management system, there is no review of vouchers or reconciliation of payments to vouchers to ensure a payee's information matches the voucher listing.</p>
Internal	Asset Misappropriation	Check Tampering	Theft	Program Employee	N/A	A Program employee redirects an ACH or wire disbursement for their personal benefit.	City: Not applicable as all payments for the Program are processed via paper check. Check disbursement is controlled by the City's Comptroller Office. Check payees require either a valid 1099 or listing in FMPS.





Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Asset Misappropriation	Cash on Hand	Theft	Program Employee	Physical Assets and Checks/Cash	A Program employee steals prepaid bank cards or other cash equivalents on hand.	<p>This type of fraud scheme differs from cash larceny and skimming in that it relates to cash that is kept in a secure place such as a bank vault. Theft of cash on hand is any scheme in which the perpetrator misappropriates cash kept on hand at the victim organization's premises (e.g., employee steals cash from a company vault).</p> <p>City: The Program regularly keeps negotiable checks in a locked drawer in the Program Director's office. The Program Director is the sole custodian of these checks. The stock of checks is the result of checks to claimants that are returned as undeliverable and awaiting pick up by the claimant. Alternatively, checks may be withheld from mail delivery - which is the primary method of benefit disbursement - due to extenuating circumstances. The Program Director keeps the key to the drawer hidden and notifies an alternate - usually Claims Counsel - as to the location of the key in her absence. There is no comprehensive mechanism to track and reconcile checks.</p>
Internal	Collusion	Bribery	N/A	Program Employee, City Employee	Compensability Determination	A Program employee accepts a bribe, or kickback, from an external party to deny a workers' compensation claim.	<p>External parties may include employers, workers, medical providers, lawyers, etc.</p> <p>City: There do not appear to be pressures to deny claims. The higher risk for the City is collusion and bribery to accept an otherwise non-compensable claim.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Collusion	Bribery	N/A	Program Employee, City Employee	Supervisor/Witness Statements	An external party makes a false statement in order to prevent someone from filing a legitimate claim.	<p>External parties may include employers, workers, medical providers, lawyers, etc. A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.</p> <p>City: There do not appear to be metrics or pressures for someone to prevent someone else from making a claim. The higher risk for the Program is collusion and bribery to falsify statements to increase a claim's likelihood of being accepted.</p>
External	Asset Misappropriation	Claimant Fraud	False Statement	City Employee	Average Weighted Wage ("AWW") Calculation, Medical bills	A worker makes a false statement in order to obtain workers' compensation benefits at an inflated rate.	<p>A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.</p> <p>City: The Program currently calculates Indemnity benefits for eligible claimants using the pay rate per FMPS. Indemnity benefits paid to claimants at a higher rate than they are entitled would require a high level of collusion between the claimant, the adjuster that calculates AWW, and Program management that reviews the calculation. There is no documented mechanism by which the Program may prevent or detect improper level of benefits.</p> <p>The Program uses a third-party provider, Coventry, to review and adjust medical bills to the Illinois fee schedule.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Collusion	Claimant Fraud	False Statement	Program Employee, City Employee	Injury on Duty Report, Supervisor/Witness Statements, Medical Bills	A worker in collusion with another external party makes a false statement in order to obtain workers' compensation benefits at an inflated rate.	External parties may include employers, workers, medical providers, lawyers, etc.  A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.  City: Investigators have been cited for not asking a sufficient number of probing questions when collecting statements from witnesses and supervisors.
Internal	Collusion	Bribery	False Statement	Program Employee, City EmployeeMedical Provider	Compensability Determination	A Program employee accepts a bribe, or kickback, from an external party to approve and/or pay a workers' compensation claim at an inflated rate based on false statements received from the external party or parties.	External parties may include employers, workers, medical providers, lawyers, etc. A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.  City: Indemnity benefits are calculated using pay data from FMPS. A monitoring mechanism for pay rates would enhance the City's ability to detect any instances of inflated benefits.



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Asset Misappropriation	Claimant Fraud	False Statement	Program Employee, City Employee	Investigations	An external party makes a false statement to the investigation staff during the course of an investigation to achieve some specific fraudulent purpose.	<p>External parties may include employers, workers, medical providers, lawyers, etc.</p> <p>A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.</p> <p>City: Investigators have been cited as not asking sufficient or appropriate probing questions to witnesses and supervisors to prevent the effects of third party statements. There would have to be a certain level of collusion between the claimant, witnesses, and/or supervisors in order for this scheme to cause harm to the Program.</p>
Internal	Collusion	Conflict of Interest	False Statement	Program Employee, City Employee	Injury on Duty Report, Voucher Creation, Medical Bills	A Program employee accepts or looks past a false statement that would result in inflated workers' compensation benefits for an external party in which they have an undisclosed conflict of interest.	<p>External parties may include employers, workers, medical providers, lawyers, etc.</p> <p>A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.</p> <p>City: Several people within the Program have anecdotally disclosed their self-recusal from claims in which they perceive to have a conflict of interest with the claimant. However, there is no documented policy that requires, or mechanism by which, Pprogram personnel can recuse themselves from claims in which there is a conflict of interest, real or perceived.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Collusion	Economic Extortion	False Statement	Program Employee, City Employee	Injury on Duty Report, Compensability Determination, Compensation Calculation	A Program employee demands personal payment from an external party as stipulation for accepting or looking past a false statement that would result in inflated workers compensation rates.	External parties may include employers, workers, medical providers, lawyers, etc. A "statement" includes any writing, notice, proof of injury, or any medical bill, record, report, or test result.  City: Medical providers would be the primary target for such extortion. Ethics policies and hotlines should be communicated to medical providers on first contact and on an ongoing periodic basis.
Internal	Corruption	Conflict of Interest	Purchasing Schemes	Program Employee	Purchasing	A Program employee directs a purchase to a company in which they have a hidden conflict of interest.	For a scheme to be classified as a purchasing scheme, the employee or perpetrator must have some kind of undisclosed interest, such as financial or familial, in the third party. An employee or agent who has an undisclosed, potentially adverse interest in a customer or supplier might be tempted to favor his own or the third party's interests over their employers.  The individual responsible for awarding or approving contracts would be in the best position to commit this scheme.





Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Corruption	Conflict of Interest	Purchasing Schemes	Program Employee	Purchasing	A Program employee attempts to influence the selection of a third party by restricting the pool of competitors from whom bids are sought - on behalf of companies in which the Program employee has a hidden conflict of interest.	<p>For a scheme to be classified as a purchasing scheme, the employee or perpetrator must have some kind of undisclosed interest, such as financial or familial, in the third party. An employee or agent who has an undisclosed, potentially adverse interest in a customer or supplier might be tempted to favor his own or the third party's interests over their employers.</p> <p>An employee is in a perfect position to manipulate bids if they have access to the competitor's bids or participates in the bidding process. With such access or responsibilities, the employee can influence the bidding process to ensure that a particular company wins the contract.</p> <p>City: Any future procurement on the Program's behalf will need to comply with City requirements.</p>
Internal	Corruption	Conflict of Interest	Purchasing Schemes	Program Employee	N/A	A Program employee approves and pays a fictitious invoice for goods or services that the City did not receive from a third party or company in which they have an undisclosed interest.	<p>For a scheme to be classified as a purchasing scheme, the employee or perpetrator must have some kind of undisclosed interest, either financial or familial, in the vendor. Purchase schemes involve the overbilling of a company for goods or services by a third party in which an employee has an undisclosed interest, ownership, or financial interest. The individual responsible for awarding or approving contracts would be in the best position to commit this scheme. The internal party might perpetrate this scheme to increase profits for the third party or company in which they have an undisclosed interest.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Corruption	Conflict of Interest	Purchasing Schemes	Program Employee	N/A	A Program employee convinces their supervisor and/or director that they need excessive or unnecessary products or services, often receiving a bribe or kickback from the third party.	<p>Procurement fraud schemes often involve collusion between contractors and the procuring entity's employees. The more power a person has over the bidding process, the more likely it is that the person can influence which entity is awarded the contract. Generally, procurement actions begin with the procuring entity making a determination of its general needs. These initial determinations include assessments of the types and amounts of goods or services required to meet the entity's needs. In these recognition schemes, procurement employees convince their employer that it needs specific or unnecessary products or services. These schemes occur in the pre-solicitation phase.</p> <p>Often, in these schemes, purchasing entity employees receive a bribe or kickback for convincing their employer to recognize a need for a particular product or service.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Corruption	Conflict of Interest	Purchasing Schemes	Program Employee	Medical Bills	A Program employee approves and pays an inflated invoice for goods or services received from a third party in which they have an undisclosed interest.	<p>For a scheme to be classified as a purchasing scheme, the employee or perpetrator must have some kind of undisclosed interest, either financial or familial, in the third party. Purchase schemes involve the overbilling of a company for goods or services by a third party in which an employee has an undisclosed interest, ownership, or financial interest. The individual responsible for awarding or approving contracts would be in the best position to commit this scheme. The internal party might perpetrate this scheme to increase profits for the third party company in which they have an undisclosed interest.</p> <p>City: This scheme would likely only apply to invoices from a SIU, external legal counsel, or bills from medical providers. However, Coventry reviews all medical bills and adjusts them to the Illinois fee schedule.</p>
Internal	Corruption	Conflict of Interest	Sales Schemes	Program Employee	Purchasing	A Program employee negotiates a purchase from a third party in which the Program employee has a hidden conflict of interest at or above market value prices.	<p>The internal party might perpetrate this scheme to increase profits for the third party in which they have an undisclosed interest.</p> <p>City: All future purchasing that might impact the Program will be handled through the City's procurement policies and procedures.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Corruption	Conflict of Interest	Sales Schemes	Program Employee	Purchasing	A Program employee causes the program to enter into an agreement for the sale of goods or services at or below market prices to a company in which the Program employee has an undisclosed interest.	There are two principal types of conflict schemes associated with sales of goods and services by the victim company: underselling and writing off sales. The first and most harmful is the underselling of goods or services. Just as a corrupt employee can cause his employer to overpay for goods and services sold by a company in which they have a hidden interest, they can also cause their employer to undersell to a company in which they maintain a hidden interest. Also, many employees who have a hidden interest in outside companies sell goods or services to these companies at or below-market prices. This results in diminished profits or even a loss for the victim company, depending on the size of the discount.
Internal	Corruption	Economic Extortion	N/A	Program Employee	Medical Bills	A Program employee demands personal payment from a third party as stipulation for award and/or continuation of a third party contract relationship.	<p>Economic extortion occurs when an employee or official, through the wrongful use of actual or threatened force or fear, demands money or some other consideration to refrain from discriminating against a business decision.</p> <p>Economic extortion is the opposite of bribery. Instead of a vendor offering payment to an employee to influence his business decision, the employee demands that the vendor pay him for favorable treatment or to avoid unfavorable treatment.</p> <p>City: Medical providers would be the primary target for such extortion. Ethics policies and hotlines should be communicated to medical providers on first contact and on an ongoing basis.</p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
Internal	Corruption	Illegal Gratuities	N/A	Program Employee	Purchasing	A Program employee accepts a personal benefit or something of value from a third party after the program employee obtains approval for the third party's contract.	<p>Illegal gratuities are something of value given to an employee to reward a decision after it has been made, rather than influence it before the decision is made. This crime is similar to bribery except that an illegal gratuity does not require proof of intent to influence the employee's decision-making. Instead of paying an employee to make a decision (e.g., award a contract), the third party pays the employee because of a decision the employee previously made. Illegal gratuities are merely offered as a "thank you" for something that has been done. In proving an illegal gratuity, there is no need to show that the third party intended to influence the employee's actions; it is enough to show that the employee accepted an award based on his performance.</p> <p>City: Procurement for the Program will be subject to the City's procurement policies and procedures.</p>
External	Asset Misappropriation	Misrepresentation of Information	N/A	City Employee	Injury on Duty Report	A supervisor makes a misrepresentation on the accident reporting form to achieve some specific fraudulent purpose.	<p>The Act requires employers (or insurers acting on their behalf) to send FROI reports to the Illinois Workers' Compensation Commission on all accidents involving more than three lost work days. FROI reports on fatal accidents are due within two work days after the death; reports on nonfatal cases shall be reported within the month. A supplementary or subsequent report should be made if it is determined that a permanent disability is involved.</p> <p>City: The Program does not have any documented mechanism by which it submits FROI reports. The City is a self-insured employer.</p>





Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Asset Misappropriation	Misrepresentation of Information	N/A	Insurer	Injury on Duty Report	An insurer makes a misrepresentation on the accident reporting form to achieve some specific fraudulent purpose.	<p>The Act requires employers (or insurers acting on their behalf) to send FROI reports to the Illinois Workers' Compensation Commission on all accidents involving more than three lost work days. FROI reports on fatal accidents are due within two work days after the death; reports on nonfatal cases shall be reported within the month. A supplementary or subsequent report should be made if it is determined that a permanent disability is involved.</p> <p>City: The Program does not have any documented mechanism by which it submits FROI reports. The City is a self-insured employer.</p>
External	Asset Misappropriation	Misrepresentation of Information	N/A	City Employee	Injury on Duty Report	A worker makes a misrepresentation on the application for benefits to achieve some specific fraudulent purpose.	<p><a href="https://www2.illinois.gov/sites/iwcc/Documents/ic01FORM.pdf">https://www2.illinois.gov/sites/iwcc/Documents/ic01FORM.pdf</a></p>
External	Asset Misappropriation	Misrepresentation of Information	N/A	Lawyer	Injury on Duty Report	A lawyer makes a misrepresentation on the application for benefits to achieve some specific fraudulent purpose.	<p><a href="https://www2.illinois.gov/sites/iwcc/Documents/ic01FORM.pdf">https://www2.illinois.gov/sites/iwcc/Documents/ic01FORM.pdf</a></p>



Internal or External	General Fraud Category	Fraud Scheme	Sub-Fraud Scheme (If Applicable)	Actor(s)	Fraud Risk Entry Point	Underlying Fraud Risk	Additional Detail & Notes (If Applicable)
External	Collusion	Misrepresentation of Information	N/A	City Employee, Lawyer	Injury on Duty Report	A worker and lawyer collude to make a misrepresentation on the application for benefits to achieve some specific fraudulent purpose.	<a href="https://www2.illinois.gov/sites/iwcc/Documents/ic01FORM.pdf">https://www2.illinois.gov/sites/iwcc/Documents/ic01FORM.pdf</a>  City: Likely not applicable as applications for benefits are submitted directly to the program.



## b. Appendix B – City of Chicago Workers Comp. Program: Detailed Claims Testing Results for Civilian Workforce

		Civilian															Civilian		
		Indemnity/Managed Medical			Medical Only			Pending			Record Only			Hennessy & Roach					
		33			17			1			2			6			Totals		
Total Number of Claims Reviewed:		Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
File Administration	Supervisor/Director Review (Best Practice)	0	33	0	0	17	0	0	1	0	0	0	2	1	5	0	1	56	2
	File Assigned within 24 hrs. (Best Practice)	28	5	0	14	3	0	1	0	0	2	0	0	6	0	0	51	8	0
	Average Weekly Wage (AWW)/Total Disability (TD) Calculated (Best Practice)	26	5	2	0	0	17	0	0	1	0	0	2	4	2	0	30	7	22
Initial File Review	Initial File Analysis within (IFA) 24/48 hrs. (Best Practice)	3	30	0	3	14	0	0	1	0	0	2	0	0	6	0	6	53	0
	Recorded Statement (Best Practice)	30	2	1	10	6	1	0	1	0	1	1	0	3	3	0	44	13	2
	Witness Statement taken (Best Practice)	12	9	12	7	6	4	0	1	0	0	1	1	3	3	0	22	20	17
	Action Plan Provided (Best Practice)	24	9	0	5	12	0	0	1	0	2	0	0	6	0	0	37	22	0
Benefit Delivery/Wages	Compensability Determination Performed (Best Practice)	30	3	0	14	1	2	0	1	0	1	1	0	2	4	0	47	10	2
	AWW/TD Rate Verified (Best Practice)	21	10	2	0	0	17	0	0	1	0	0	2	0	5	1	21	15	23
	Stop TD Letters (State Regulation Section 9110.70)	9	13	11	0	0	17	0	0	1	0	0	2	1	4	1	10	17	32
	Overpayment On File (Best Practice)	6	25	2	0	0	17	0	0	1	0	0	2	0	6	0	6	31	22
Medical Review	Medical Analysis Completed (Best Practice)	16	15	2	4	11	2	0	1	0	0	0	2	4	2	0	24	29	6
	Medical Authorization Request Sent (Best Practice)	25	8	0	5	11	1	0	1	0	0	2	0	4	2	0	34	24	1
	Medical Canvas Performed (Best Practice)	6	21	6	0	14	3	0	1	0	0	0	2	1	5	0	7	41	11
	Drug Test Performed (Best Practice)	25	8	0	7	5	5	0	1	0	0	0	2	4	2	0	36	16	7
Forms	FROI Filed (State Regulation/Requirement)	0	33	0	0	0	17	0	0	1	0	0	2	0	6	0	0	39	20
	Delay Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	24	9	0	16	1	0	1	0	0	2	0	0	3	3	0	46	13
	Denial Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	3	30	0	7	10	0	0	1	0	1	1	0	1	5	0	12	47
	Settlement/Reserve Analysis (Best Practice)	1	24	8	0	0	17	0	0	1	0	0	2	0	3	3	1	27	31
Reserves	Reserves Set Timely (5-14 Business Days): Best Practice)	29	4	0	16	1	0	1	0	0	2	0	0	5	1	0	53	6	0



		Civilian															Civilian		
		Indemnity/Managed Medical			Medical Only			Pending			Record Only			Hennessy & Roach					
Total Number of Claims Reviewed:		33			17			1			2			6			Totals		
		Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Subrogation	Reserve Exposure Set (Best Practice)	6	27	0	5	6	6	0	1	0	0	1	1	0	5	1	11	40	8
	Stair-stepping (Set as bills are received) (Best Practice)	24	6	3	3	2	12	0	0	1	0	0	2	2	2	2	29	10	20
	Third Party Potential Assessed (Best Practice)	1	4	28	0	3	14	0	0	1	0	0	2	0	3	3	1	10	48
	Liability Analysis Provided (Best Practice)	0	1	32	0	0	17	0	0	1	0	0	2	0	0	6	0	1	58
	Recovery Received (Best Practice)	1	5	27	0	3	14	0	0	1	0	0	2	0	3	3	1	0	58
Litigation	IFA Litigation Summary (Best Practice)	0	19	14	0	0	17	0	0	1	0	0	2	1	5	0	1	24	34
	Budget (Best Practice)	0	17	16	0	0	17	0	0	1	0	0	2	0	6	0	0	23	36
	Settlement Authorization Requested (Best Practice)	0	16	17	0	0	17	0	0	1	0	0	2	0	2	4	0	18	41
Closure	File Aggressively Handled (Best Practice)	9	23	1	4	13	0	0	1	0	1	1	0	0	6	0	14	44	1
	All Bills Paid (Best Practice)	16	8	9	4	4	9	0	0	1	0	0	2	4	1	1	24	13	22
	Closed Timely (Best Practice)	9	15	9	1	15	1	0	1	0	2	0	0	0	2	4	12	33	14
Miscellaneous	Return To Work Addressed (RTW) (Best Practice)	12	15	6	0	0	17	0	0	1	0	0	2	3	1	2	15	16	28
	Surveillance Assigned (Best Practice)	11	4	18	0	0	17	0	0	1	0	0	2	2	2	2	13	6	40
	Medicare Verified (Federal Regulation)	30	0	3	0	0	17	0	0	1	0	0	2	0	0	6	30	0	29
Diary Completed (Best Practice)		28	5	0	6	11	0	0	1	0	1	1	0	3	3	0	38	21	0





**c. Appendix C – City of Chicago Workers Comp. Program: Detailed Claims Testing Results for Police and Fire Workforce**

		Police & Fire												Police & Fire		
		Indemnity/Managed Medical			Medical Only			Pending			Record Only					
		Total Number of Claims Reviewed:												Totals		
		Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
File Administration	Supervisor/Director Review (Best Practice)	0	5	0	0	17	0	1	0	0	0	2	0	1	24	0
	File Assigned within 24 hrs. (Best Practice)	5	0	0	17	0	0	1	0	0	2	0	0	25	0	0
	Average Weekly Wage (AWW)/Total Disability (TD) Calculated (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
Initial File Review	Initial File Analysis within (IFA) 24/48 hrs. (Best Practice)	0	5	0	5	12	0	0	1	0	1	1	0	6	19	0
	Recorded Statement (Best Practice)	0	5	0	0	17	0	0	0	1	0	2	0	0	24	1
	Witness Statement taken (Best Practice)	0	3	2	0	4	13	0	0	1	0	1	1	0	8	17
	Action Plan Provided (Best Practice)	0	5	0	5	12	0	1	0	0	2	0	0	8	17	0
	Compensability Determination Performed (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
Benefit Delivery/Wages	AWW/TD Rate Verified (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Stop TD Letters (State Regulation Section 9110.70)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Overpayment On File (Best Practice)	0	5	0	0	0	17	0	0	1	0	0	2	0	0	25
Medical Review	Medical Analysis Completed (Best Practice)	1	4	0	0	17	0	0	0	1	0	2	0	1	23	1
	Medical Authorization Request Sent (Best Practice)	0	5	0	0	17	0	0	0	1	0	2	0	0	24	1





Total Number of Claims Reviewed:		Police & Fire												Police & Fire		
		Indemnity/Managed Medical			Medical Only			Pending			Record Only					
		5			17			1			2			Totals		
		Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Forms	Medical Canvas Performed (Best Practice)	0	5	0	0	17	0	0	0	1	0	2	0	0	24	1
	Drug Test Performed (Best Practice)	0	5	0	0	17	0	0	0	1	0	1	1	0	23	2
	FROI Filed (State Regulation/Requirement)	0	5	0	0	17	0	0	1	0	0	2	0	0	0	25
	Delay Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Denial Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	0	5	2	1	14	0	0	1	0	1	1	2	2	21
	Settlement/Reserve Analysis (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
Reserves	Reserves Set Timely (5-14 Business Days): Best Practice)	5	0	0	17	0	0	1	0	0	0	1	1	23	1	1
	Reserve Exposure Set (Best Practice)	0	5	0	3	13	1	0	1	0	0	1	1	3	20	2
	Stair-stepping (Set as bills are received) (Best Practice)	5	0	0	15	1	1	1	0	0	1	0	1	22	1	2
Subrogation	Third Party Potential Assessed (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Liability Analysis Provided (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Recovery Received (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
Litigation	IFA Litigation Summary (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Budget (Best Practice	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Settlement Authorization Requested (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
Closure	File Aggressively Handled (Best Practice)	0	5	0	2	15	0	0	1	0	0	1	1	2	22	1
	All Bills Paid (Best Practice)	2	2	1	5	4	8	0	0	1	0	0	2	7	6	12
	Closed Timely (Best Practice)	3	2	0	5	10	2	0	0	1	1	1	0	9	13	3
Miscellaneous	Return To Work Addressed (RTW) (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Surveillance Assigned (Best Practice)	0	0	5	0	0	17	0	0	1	0	0	2	0	0	25
	Medicare Verified (Federal Regulation)	5	0	0	0		17	0	0	1	0	0	2	5	0	20
	Diary Completed (Best Practice)	5	0	0	13	4	0	0	1	0	1	1	0	19	6	0



**d. Appendix D – Detailed Testing Results from CCMSI for Federally Funded Civilian**

		Federally Funded						Federally Funded		
		Indemnity/Managed Medical			Medical Only					
Total Number of Claims Reviewed:		2			3			Totals		
		Y	N	N/A	Y	N	N/A	Y	N	N/A
File Administration	Supervisor/Director Review (Best Practice)	2	0	0	3	0	0	5	0	0
	File Assigned within 24 hrs. (Best Practice)	2	0	0	3	0	0	5	0	0
	Average Weekly Wage (AWW)/Total Disability (TD) Calculated (Best Practice)	2	0	0	3	0	0	5	0	0
Initial File Review	Initial File Analysis within (IFA) 24/48 hrs. (Best Practice)	2	0	0	3	0	0	5	0	0
	Recorded Statement (Best Practice)	2	0	0	0	0	3	2	0	3
	Witness Statement taken (Best Practice)	0	0	2	0	0	3	0	0	5
	Action Plan Provided (Best Practice)	2	0	0	3	0	0	5	0	0
Benefit Delivery/Wages	Compensability Determination Performed (Best Practice)	2	0	0	3	0	0	5	0	0
	AWW/TD Rate Verified (Best Practice)	2	0	0	3	0	0	5	0	0
	Stop TD Letters (State Regulation Section 9110.70)	0	2	0	0	0	3	0	2	3
	Overpayment On File (Best Practice)	1	1	0	0	3	0	1	4	0
Medical Review	Medical Analysis Completed (Best Practice)	2	0	0	3	0	0	5	0	0
	Medical Authorization Request Sent (Best Practice)	2	0	0	3	0	0	5	0	0
	Medical Canvas Performed (Best Practice)	2	0	0	3	0	0	5	0	0
	Drug Test Performed (Best Practice)	2	0	0	3	0	0	5	0	0
Forms	FROI Filed (State Regulation/Requirement)	1	1	0	0	0	3	1	1	3
	Delay Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	0	2	0	0	3	0	0	5
	Denial Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	0	2	1	0	2	1	0	4
	Settlement/Reserve Analysis (Best Practice)	0	0	2	0	0	3	0	0	5
Reserves	Reserves Set Timely (5-14 Business Days): Best Practice)	2	0	0	2	1	0	4	1	0
	Reserve Exposure Set (Best Practice)	2	0	0	3	0	0	5	0	0



		Federally Funded						Federally Funded		
		Indemnity/Managed Medical			Medical Only					
		2			3			Totals		
Total Number of Claims Reviewed:		Y	N	N/A	Y	N	N/A	Y	N	N/A
Subrogation	Stair-stepping (Set as bills are received) (Best Practice)	0	0	2	0	0	3	0	0	5
	Third Party Potential Assessed (Best Practice)	2	0	0	3	0	0	5	0	0
	Liability Analysis Provided (Best Practice)	0	0	2	0	0	3	0	0	5
	Recovery Received (Best Practice)	1	0	1	0	0	3	1	0	4
Litigation	IFA Litigation Summary (Best Practice)	0	0	2	0	0	3	0	0	5
	Budget (Best Practice)	0	0	2	0	0	3	0	0	5
	Settlement Authorization Requested (Best Practice)	0	0	2	0	0	3	0	0	5
Closure	File Aggressively Handled (Best Practice)	2	0	0	3	0	0	5	0	0
	All Bills Paid (Best Practice)	2	0	0	3	0	0	5	0	0
	Closed Timely (Best Practice)	2	0	0	3	0	0	5	0	0
Miscellaneous	Return To Work Addressed (RTW) (Best Practice)	2	0	0	3	0	0	5	0	0
	Surveillance Assigned (Best Practice)	0	2	0	0	3	0	0	5	0
	Medicare Verified (Federal Regulation)	2	0	0	3	0	0	5	0	0
	Diary Completed (Best Practice)	2	0	0	3	0	0	5	0	0





e. Appendix E – Detailed Testing Results from CCMSI for Aviation Employees

		Aviation									Aviation		
		Indemnity/Managed Medical			Medical Only			Incident Only					
		Total Number of Claims Reviewed:									Totals		
		Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
File Administration	Supervisor/Director Review (Best Practice)	8	0	1	8	0	0	3	0	0	19	0	1
	File Assigned within 24 hrs. (Best Practice)	9	0	0	8	0	0	3	0	0	20	0	0
	Average Weekly Wage (AWW)/Total Disability (TD) Calculated (Best Practice)	8	0	1	4	0	4	0	0	3	12	0	8
Initial File Review	Initial File Analysis within (IFA) 24/48 hrs. (Best Practice)	9	0	0	8	0	0	3	0	0	20	0	0
	Recorded Statement (Best Practice)	8	1	0	6	1	1	2	1	0	16	3	1
	Witness Statement taken (Best Practice)	2	3	4	1	2	5	0	0	3	3	5	12
	Action Plan Provided (Best Practice)	9	0	0	7	0	1	3	0	0	19	0	1
	Compensability Determination Performed (Best Practice)	8	1	0	8	0	0	0	2	1	16	3	1
Benefit Delivery/Wages	AWW/TD Rate Verified (Best Practice)	7	1	1	4	0	4	0	0	3	11	1	8
	Stop TD Letters (State Regulation Section 9110.70)	0	5	4	0	0	8	0	0	3	0	5	15
	Overpayment On File (Best Practice)	0	2	7	0	6	2	0	0	3	0	8	12
Medical Review	Medical Analysis Completed (Best Practice)	9	0	0	7	0	1	0	0	3	16	0	4
	Medical Authorization Request Sent (Best Practice)	7	2	0	5	2	1	0	0	3	12	4	4
	Medical Canvas Performed (Best Practice)	9	0	0	3	2	3	0	0	3	12	2	6
	Drug Test Performed (Best Practice)	3	3	3	3	1	4	1	0	2	7	4	9
Forms	FROI Filed (State Regulation/Requirement)	9	0	0	7	0	1	0	0	3	16	0	4
	Delay Letter sent - Within 14 Days (State Regulation Section 9110.70)	0	2	7	0	0	8	0	0	3	0	2	18
	Denial Letter sent - Within 14 Days (State Regulation Section 9110.70)	1	0	8	1	0	7	0	0	3	2	0	18
	Settlement/Reserve Analysis (Best Practice)	9	0	0	5	0	3	0	0	3	14	0	6
Reserves	Reserves Set Timely (5-14 Business Days): Best Practice)	9	0	0	8	0	0	0	0	3	17	0	3
	Reserve Exposure Set (Best Practice)	9	0	0	8	0	0	0	0	3	17	0	3



		Aviation									Aviation		
		Indemnity/Managed Medical			Medical Only			Incident Only					
		9			8			3			Totals		
Total Number of Claims Reviewed:		Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Subrogation	Stair-stepping (Set as bills are received) (Best Practice)	0	0	9	0	0	8	0	0	3	0	0	20
	Third Party Potential Assessed (Best Practice)	9	0	0	8	0	0	3	0	0	20	0	0
	Liability Analysis Provided (Best Practice)	2	0	7	0	0	8	0	0	3	2	0	18
	Recovery Received (Best Practice)	0	1	8	0	0	8	0	0	3	0	1	19
Litigation	IFA Litigation Summary (Best Practice)	2	0	7	0	2	6	0	0	3	2	2	16
	Budget (Best Practice)	1	1	7	0	2	6	0	0	3	1	3	16
	Settlement Authorization Requested (Best Practice)	1	0	8	1	1	6	0	0	3	2	1	17
Closure	File Aggressively Handled (Best Practice)	5	0	4	5	0	3	0	0	3	10	0	10
	All Bills Paid (Best Practice)	5	0	4	5	0	3	0	0	3	10	0	10
	Closed Timely (Best Practice)	4	1	4	5	0	3	3	0	0	12	1	7
Miscellaneous	Return To Work Addressed (RTW) (Best Practice)	6	0	3	6	0	2	0	0	3	12	0	8
	Surveillance Assigned (Best Practice)	0	0	9	0	0	8	0	0	3	0	0	20
	Medicare Verified (Federal Regulation)	9	0	0	8	0	0	0	0	3	17	0	3
	Diary Completed (Best Practice)	9	0	0	7	1	0	0	0	3	16	1	3





**f. Appendix F – Top 20 Claims by Civilian, Police and Fire, Federally Funded Civilian, and Aviation**

Top 20 Police and Fire Claim Payments	Top 20 Civilian Claim Payments
\$171,165	\$959,611
\$145,435	\$258,068
\$118,281	\$224,189
\$116,529	\$216,982
\$115,145	\$210,145
\$103,132	\$207,548
\$101,273	\$203,635
\$97,987	\$203,483
\$97,975	\$196,896
\$96,149	\$195,595
\$92,189	\$185,668
\$85,463	\$185,180
\$83,558	\$178,938
\$83,539	\$176,479
\$81,669	\$175,814
\$81,658	\$171,685
\$81,642	\$170,966
\$81,319	\$169,400
\$80,951	\$166,603
\$80,764	\$159,713



Top 20 Federally Funded Civilian Claim Payments	Top 20 Aviation Claim Payments
\$94,555	\$141,319
\$22,341	\$120,044
\$21,504	\$82,727
\$19,766	\$75,092
\$19,683	\$74,345
\$17,871	\$65,990
\$17,598	\$64,233
\$17,432	\$63,869
\$15,908	\$63,169
\$13,870	\$54,867
\$7,775	\$52,415
\$6,516	\$50,908
\$6,110	\$48,338
\$3,701	\$48,299
\$3,321	\$47,881
\$3,108	\$46,961
\$2,050	\$43,763
\$1,631	\$43,027
\$908	\$42,768
\$805	\$42,025



**g. Appendix G – Number of Days Between Injury Date and System Add for Civilian Police and Fire Claims:**

Days Between Injury Date and System Add Date Civilian & Police and Fire Claims	
Number of Days	Number of Claims
219	1
147	1
142	1
115	1
109	1
107	2
104	1
102	1
98	1
97	1
89	3
87	1
86	1
84	1
82	1
79	2
67	1
65	2
64	1
63	1
62	1



Days Between Injury Date and System Add Date Civilian & Police and Fire Claims	
Number of Days	Number of Claims
58	2
56	1
55	1
53	1
51	1
49	1
48	1
43	3
42	1
41	2
39	2
37	2
36	1
35	5
34	2
32	2
30	3
29	4
28	6
27	2
26	2
25	4
24	2

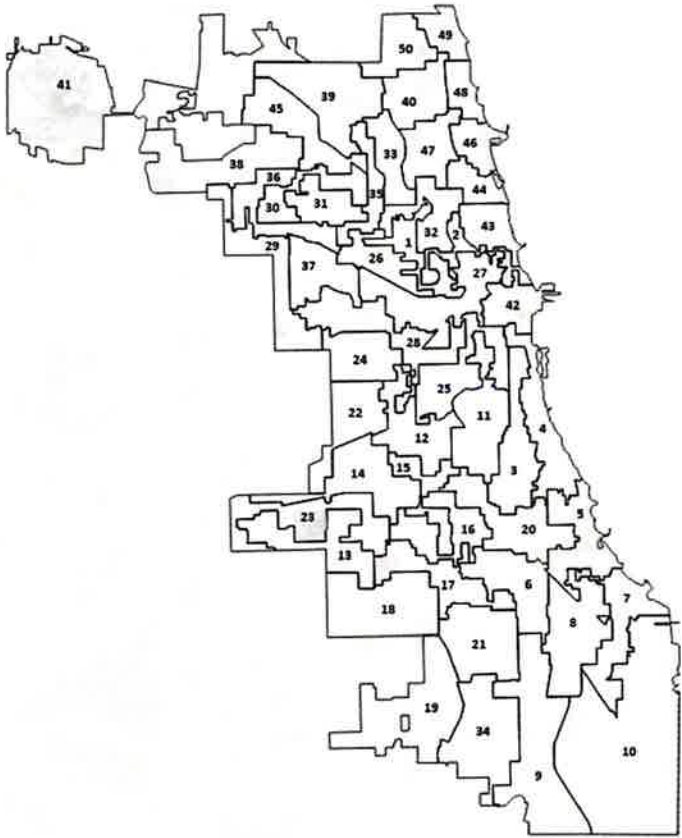


Days Between Injury Date and System Add Date Civilian & Police and Fire Claims	
Number of Days	Number of Claims
23	4
22	2
21	8
20	2
19	6
18	3
17	5
16	4
15	14
14	12
13	18
12	18
11	12
10	16
9	22
8	56
7	74
6	88
5	130
4	157
3	188





**h. Appendix H – City of Chicago Ward Boundaries Legend**



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i. Appendix I – City of Chicago Aldermanic Wards and Zip Codes

Ward	Alderman	Zip Codes							
1	Proco "Joe" Moreno	60612	60618	60622	60642	60647			
2	Brian Hopkins	60610	60611	60614	60622	60642	60647	60654	
3	Pat Dowell	60605	60609	60615	60616	60621	60637	60653	
4	Sophia King	60604	60605	60615	60616	60653			
5	Leslie A. Hairston	60615	60619	60637	60649				
6	Roderick T. Sawyer	60619	60620	60621	60636	60637			
7	Gregory I. Mitchell	60617	60619	60649					
8	Michelle A. Harris	60617	60619	60628	60649				
9	Anthony A. Beale	60619	60628	60827					
10	Susan Sadlowski Garza	60617	60628	60633					
11	Patrick Daley Thompson	60607	60608	60609	60616				
12	George Cardenas	60608	60609	60623	60632				
13	Marty Quinn	60629	60632	60638	60652				
14	Edward M. Burke	60623	60629	60632	60638				
15	Raymond A. Lopez	60609	60629	60632	60636				
16	Toni L. Foulkes	60609	60621	60629	60636				
17	David H. Moore	60620	60621	60629	60636				
18	Derrick G. Curtis	60620	60629	60636	60652				
19	Matthew J. O'Shea	60620	60643	60655					
20	Willie B. Cochran	60609	60615	60621	60637				
21	Howard B. Brookins, Jr.	60620	60628	60643					
22	Ricardo Munoz	60623	60632	60638					
23	Silvana Taberas	60629	60632	60638					
24	Michael Scott, Jr.	60608	60612	60623	60624	60644			



Ward	Alderman	Zip Codes								
25	Daniel "Danny" Solis	60605	60607	60608	60616					
26	Roberto Maldonado	60612	60622	60639	60647	60651				
27	Walter Burnett, Jr.	60607	60610	60612	60622	60624	60642	60651	60654	
28	Jason C. Ervin	60607	60608	60612	60624	60644				
29	Chris Taliaferro	60634	60639	60644	60651	60707				
30	Ariel E. Reboyras	60618	60634	60639	60641					
31	Milagros "Milly" Santiago	60634	60639	60641	60647					
32	Scott Waguespack	60614	60618	60622	60642	60647	60657			
33	Deborah Mell	60618	60625							
34	Carrie M. Austin	60628	60643							
35	Carlos Ramirez-Rosa	60618	60625	60630	60639	60647				
36	Gilbert Villegas	60634	60639	60641	60707					
37	Emma M. Mitts	60624	60639	60644	60651					
38	Nicholas Sposato	60630	60634	60641	60656					
39	Margaret Laurino	60618	60625	60630	60641	60646	60659			
40	Patrick J. O'Connor	60625	60626	60640	60659	60660				
41	Anthony V. Napolitano	60631	60646	60656						
42	Brendan Reilly	60601	60602	60603	60604	60605	60606	60611	60654	60661
43	Michelle Smith	60610	60614							
44	Tom Tunney	60613	60657							
45	John S. Arena	60618	60630	60641	60646	60656				
46	James Cappleman	60613	60640	60657						
47	Ameya Pawar	60613	60618	60625	60640	60657				
48	Harry Osterman	60640	60660							
49	Joe Moore	60626	60645							
50	Debra L. Silverstein	60626	60645	60659						



j. Appendix J – Zip Codes by Claims and Active Employees Analysis<sup>20</sup>

Total Active Employees <sup>21</sup>	33,498
Total Claims	4,959
Total Police and Fire Claims	3,000
Total Civilian Claims	1,845
Total Aviation Claims	114

Zip Code	Claims				Active Employees	Percent Analysis				
	Aviation	Civilian	P&F	Total	Number	% of Active Employees	% of Total Claims	% of Aviation	% of Civilian	% of P&F
60655	2	93	396	491	3,231	9.65%	9.90%	1.75%	5.04%	13.20%
60638	16	145	329	490	2,724	8.13%	9.88%	14.04%	7.86%	10.97%
60634	12	96	253	361	1,836	5.48%	7.28%	10.53%	5.20%	8.43%
60631	9	48	273	330	2,146	6.41%	6.65%	7.89%	2.60%	9.10%
60656	8	32	166	206	1,273	3.80%	4.15%	7.02%	1.73%	5.53%

<sup>20</sup> Zip code data was not provided for Federally Funded Civilians, therefore a zip code analysis could not be completed for these claims.

<sup>21</sup> This analysis was completed based on data available from the OIG’s “Map: City Active Employees by Ward and Zip Code” dashboard. The OIG’s dashboard is updated weekly, therefore, data used for this analysis reflect current active employees as of May 2, 2019. Zip codes with claims data without employee data in the OIG’s dashboard are displayed as “NA”. The OIG dashboard does not provide a breakdown of active employees by employee group by zip code.



Zip Code	Claims				Active Employees	Percent Analysis				
	Aviation	Civilian	P&F	Total		% of Active Employees	% of Total Claims	% of Aviation	% of Civilian	% of P&F
60643	2	75	119	196	1,517	4.53%	3.95%	1.75%	4.07%	3.97%
60652	3	78	97	178	1,228	3.67%	3.59%	2.63%	4.23%	3.23%
60630	2	28	142	172	1,081	3.23%	3.47%	1.75%	1.52%	4.73%
60646	3	25	132	160	1,159	3.46%	3.23%	2.63%	1.36%	4.40%
60628	6	108	46	160	933	2.79%	3.23%	5.26%	5.85%	1.53%
60617	3	92	51	146	1,058	3.16%	2.94%	2.63%	4.99%	1.70%
60619	3	101	40	144	889	2.65%	2.90%	2.63%	5.47%	1.33%
60620	2	75	50	127	908	2.71%	2.56%	1.75%	4.07%	1.67%
60629	2	69	55	126	855	2.55%	2.54%	1.75%	3.74%	1.83%
60641	2	41	72	115	628	1.87%	2.32%	1.75%	2.22%	2.40%
60618	1	22	77	100	657	1.96%	2.02%	0.88%	1.19%	2.57%
60609	1	65	31	97	680	2.03%	1.96%	0.88%	3.52%	1.03%
60608	7	27	58	92	649	1.94%	1.86%	6.14%	1.46%	1.93%
60639	3	50	36	89	523	1.56%	1.79%	2.63%	2.71%	1.20%
60651	1	43	27	71	454	1.36%	1.43%	0.88%	2.33%	0.90%
60616	2	35	33	70	623	1.86%	1.41%	1.75%	1.90%	1.10%
60649	1	45	21	67	412	1.23%	1.35%	0.88%	2.44%	0.70%





Zip Code	Claims				Active Employees	Percent Analysis				
	Aviation	Civilian	P&F	Total	Number	% of Active Employees	% of Total Claims	% of Aviation	% of Civilian	% of P&F
60647	4	17	40	61	465	1.39%	1.23%	3.51%	0.92%	1.33%
60707	6	18	35	59	384	1.15%	1.19%	5.26%	0.98%	1.17%
60644	0	42	14	56	353	1.05%	1.13%	0.00%	2.28%	0.47%
60632	0	34	18	52	443	1.32%	1.05%	0.00%	1.84%	0.60%
60653	1	23	28	52	422	1.26%	1.05%	0.88%	1.25%	0.93%
60659	0	16	32	48	261	0.78%	0.97%	0.00%	0.87%	1.07%
60636	0	42	4	46	208	0.62%	0.93%	0.00%	2.28%	0.13%
60615	1	20	24	45	381	1.14%	0.91%	0.88%	1.08%	0.80%
60612	1	27	17	45	345	1.03%	0.91%	0.88%	1.46%	0.57%
60623	2	28	13	43	388	1.16%	0.87%	1.75%	1.52%	0.43%
60637	1	28	13	42	332	0.99%	0.85%	0.88%	1.52%	0.43%
60633	0	19	23	42	333	0.99%	0.85%	0.00%	1.03%	0.77%
60645	1	14	24	39	284	0.85%	0.79%	0.88%	0.76%	0.80%
60624	1	32	5	38	258	0.77%	0.77%	0.88%	1.73%	0.17%
60625	0	5	32	37	402	1.20%	0.75%	0.00%	0.27%	1.07%
60622	2	11	21	34	282	0.84%	0.69%	1.75%	0.60%	0.70%
60621	0	27	6	33	177	0.53%	0.67%	0.00%	1.46%	0.20%



	Claims				Active Employees	Percent Analysis				
Zip Code	Aviation	Civilian	P&F	Total	Number	% of Active Employees	% of Total Claims	% of Aviation	% of Civilian	% of P&F
60640	0	8	21	29	313	0.93%	0.58%	0.00%	0.43%	0.70%
60607	0	0	24	24	183	0.55%	0.48%	0.00%	0.00%	0.80%
60626	0	6	14	20	244	0.73%	0.40%	0.00%	0.33%	0.47%
60613	1	3	15	19	243	0.73%	0.38%	0.88%	0.16%	0.50%
60660	0	3	14	17	196	0.59%	0.34%	0.00%	0.16%	0.47%
60657	0	4	13	17	226	0.67%	0.34%	0.00%	0.22%	0.43%
60614	0	5	11	16	156	0.47%	0.32%	0.00%	0.27%	0.37%
60610	0	4	5	9	133	0.40%	0.18%	0.00%	0.22%	0.17%
60642	0	4	4	8	102	0.30%	0.16%	0.00%	0.22%	0.13%
60605	0	1	6	7	165	0.49%	0.14%	0.00%	0.05%	0.20%
60601	0	0	5	5	55	0.16%	0.10%	0.00%	0.00%	0.17%
60611	0	0	4	4	86	0.26%	0.08%	0.00%	0.00%	0.13%
60654	0	1	3	4	138	0.41%	0.08%	0.00%	0.05%	0.10%
60635	0	2	1	3	NA	NA	0.06%	0.00%	0.11%	0.03%
60661	1	2	0	3	28	0.08%	0.06%	0.88%	0.11%	0.00%
60604	0	2	1	3	6	0.02%	0.06%	0.00%	0.11%	0.03%
60805	0	0	2	2	NA	NA	0.04%	0.00%	0.00%	0.07%



Zip Code	Claims				Active Employees	Percent Analysis				
	Aviation	Civilian	P&F	Total	Number	% of Active Employees	% of Total Claims	% of Aviation	% of Civilian	% of P&F
60606	0	2	0	2	11	0.03%	0.04%	0.00%	0.11%	0.00%
60827	0	2	0	2	23	0.07%	0.04%	0.00%	0.11%	0.00%
60452	0	0	2	2	NA	NA	0.04%	0.00%	0.00%	0.07%
60478	1	0	0	1	NA	NA	0.02%	0.88%	0.00%	0.00%
60098	0	0	1	1	NA	NA	0.02%	0.00%	0.00%	0.03%
60477	0	0	1	1	NA	NA	0.02%	0.00%	0.00%	0.03%